

PROS AND CONS OF DRUG LEGALIZATION, DECRIMINALIZATION, AND HARM REDUCTION

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIMINAL JUSTICE,
DRUG POLICY, AND HUMAN RESOURCES

OF THE

COMMITTEE ON
GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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PROS AND CONS OF DRUG LEGALIZATION, DECRIMINALIZATION, AND HARM REDUCTION

WEDNESDAY, JUNE 16, 1999

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY,
AND HUMAN RESOURCES,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:15 a.m., in room 2154, Rayburn House Office Building, Hon. John L. Mica (chairman of the subcommittee) presiding.

Present: Representatives Mica, Barr, Gilman, Souder, Hutchinson, Ose, Mink, Towns, Cummings and Kucinich.

Staff present: Robert Charles, staff director/chief counsel; Andrew Greeley, clerk; Sean Littlefield and Gilbert Macklin, professional staff members; Rob Mobley, congressional fellow; Cherri Branson, minority counsel; and Ellen Rayner, minority chief clerk.

Mr. MICA. Good morning, I would like to welcome you to this meeting of the Subcommittee on Criminal Justice, Drug Policy, and Human Resources and call this hearing to order.

It is my understanding that they are concluding a Democratic Caucus, and we should be joined by members from the minority side. The Republicans are having a conference which is just concluding, and we should be joined by members from the majority side in just a few minutes. But we will go ahead and begin.

I have an opening statement and I will be followed by others who have opening statements today. We have three panels that we will hear from.

The subject of today's hearing is the pros and cons of drug legalization, decriminalization, and harm reduction. Today the Subcommittee on Criminal Justice, Drug Policy, and Human Resources will examine a subject which is frequently talked about but rarely the topic of a congressional hearing—that is the question of drug legalization. Specifically, we will discuss issues relating to drug use, drug offenses, decriminalization, and harm reduction.

This hearing is just one more in a series of hearings that we have held and will continue to hold examining our Nation's drug control policy and its effectiveness. As you know, recent statistics on drug use by young people are not just worrisome, they are tragic and sobering. Methods to deter the use and abuse of dangerous substances should be the centerpiece of any serious effort to reverse the rising drug use trends.

The simple truth is that drugs destroy lives. They steal away opportunities that might have been. They produce fatal overdoses, fatal accidents, and death by criminal homicide.

Despite the warm glow of well-intentioned words, the reality is hard to miss. Drug overdose deaths continue to plague our metropolitan areas, our suburbs, and our schools. There is really no element of our society today untouched by the ravages of illegal narcotics. Drug use is soaring among our 12th graders. More than 50 percent of them have tried an illicit drug, and more than one in four are today a current user.

There have been serious proposals across our land and here in Washington about how to best combat school violence and deal with drug traffickers, restore individual and community security, and reduce overall youth drug use. These proposals have ranged from legalization of marijuana for medical use to tough sentencing guidelines and needle exchanges.

Today, we venture into a first-of-its-kind hearing with this subcommittee's undertaking to provide new information and also solicit informed opinions from both the policymakers and the public on issues relating to drug legalization and decriminalization. The often high-pitched debate over legalization of drugs appears to have intensified during the past several years. There appears to be more public support for these initiatives than there was several years ago when they were first proposed.

My concern is that the media and other opinion leaders are paying more attention to drug legalization because there has been in fact a well-financed and internationally and nationally coordinated effort championed by several organizations and wealthy backers. Quite frankly, I am not certain of their motivation, and I am not certain of their end game.

Regardless of which seed bed this movement is sprouting from, the issue needs to be openly and honestly addressed by both government and nongovernmental officials. That is why I decided to conduct this hearing and conduct additional hearings on this subject. That is why today we are bringing together Federal officials with responsibility in this area and a sampling of outside policy experts. The notion that dangerous drugs might one day be legalized has come from a number of sources, including former Surgeon General Joycelyn Elders, mayor of Baltimore Kurt Schmoke, the press, and other opinion leaders.

If this debate is going to be, as Justice Brennan once said, as all controversial debates should be, open and robust, it must at last be joined. Honest debate over these issues, I believe, will benefit the American people. Hopefully, we can also act to discredit those who promote positions without a basis in fact and add credibility to those who have facts on their side. The American public should understand the policy implications of legalization, decriminalization and harm reduction. They need to hear both sides of this debate, that is why we begin today, hopefully, in a civil and well-informed discussion.

There are many facets and nuances to this debate. However, I would like to take just a few moments to share my personal views on several issues.

As many of you know, I have been highly critical at times of this administration's drug policies and budget priorities. For a number of years, this administration floundered without specific goals or objectives in a coherent drug control policy. General McCaffrey has helped to change that direction, but in the prior leadership vacuum, substantial ground was lost and the war on drugs was nearly closed down. That said, I believe this void helped provide momentum to the current drive toward legalization and decriminalization.

The problems associated with drug use are not simple and will not respond to simple solutions. I believe that there have been victories and successes in the fight against drug trafficking and drug use and abuse; however in my own view, we can and must do more. The alternative isn't very pretty. In fact, the alternative may be consigning a generation to addiction and drug dependency in unprecedented numbers. We cannot step backward after beginning to move forward.

The 50 percent drop in drug users, from 15.4 million in 1979 to a little over 12 million in 1992, and the 75 percent drop in cocaine use between a measured peak in 1985 of 5.7 million to a bottom of 1.4 million in 1992 are what I would term successes. As many of you know, these successes were the combined result of a strong parents' movement and a strong Federal antidrug policy. In New York City, we have seen that tough enforcement has reduced crime, murder, and drug abuse.

In the past few years, we have restarted, I believe, effective eradication and source country programs. We have also begun an unprecedented education and demand reduction program. It is important that before we reverse course, we must carefully examine what has worked and what has failed. If we can identify effective treatment for those incarcerated or those afflicted with drug addiction, nothing should stand in our way to provide care to those individuals. However, we cannot turn our backs on felonious conduct and issue those who traffic and deal in deadly substances a license to destroy lives.

Today's hearing solicits initial comments from this administration; and, as I said, we will have a sampling of experts on the subject today. This is our first hearing in a series of hearings that I hope will provide factual testimony on the questions of drug legalization, decriminalization and harm reduction.

Those are my opening comments. As I said, we have three panels we will hear from shortly.

I am pleased that we have been joined by our ranking member. I know she may be out of breath in running back, but I am delighted to recognize her at this time, the gentlelady and ranking member, as I said, Mrs. Mink from Hawaii. You are recognized.

Mrs. MINK. I thank you, Mr. Chairman. I do apologize for being late.

The Democratic Caucus was convened this morning on a very important matter: juvenile justice. The majority leadership reoriented the debate procedure, as you know, at the last minute so we have been trying to sort things out. Half of the bill came out of my Committee on Education and the Workforce, which has now been pulled, so things are in somewhat of a disarray, and I apologize for being late.

I will insert my remarks at a later point. I would like at this time to yield a few minutes to Dennis Kucinich, who has an introduction to make.

Mr. KUCINICH. With the permission of the chair, with unanimous consent, I would like to introduce——

Mr. MICA. Without objection.

Mr. KUCINICH. Thank you very much. I would like to introduce Kevin Sabbitt from the Community Antidrug Coalition. If Kevin could stand. Kevin is one of the many young people from across this country who is working on strategies to quell the use of drugs in communities. He had some remarks, with the permission of the chair, I would like with unanimous consent to be included in the record.

Mr. MICA. Without objection, so ordered.

Mr. KUCINICH. I might mention that Kevin's involvement and testimony was called to my attention by the wife of the Governor of the State of Ohio, Mrs. Hope Taft, who called me and asked me if I would communicate this to the chair. I would certainly appreciate your indulgence and the committee's indulgence.

Mr. MICA. We are very pleased for his participation. Without objection, his remarks will be made a part of the record.

Mr. KUCINICH. Thank you. Mrs. Mink, thank you.

Mr. MICA. Thank you.

[The information referred to follows:]

Submitted by Kevin A. Sabet

June 16, 1999

**Subcommittee on Criminal Justice, Drug Policy, and Human
Resources
Hearing on Drug Legalization**

The dialogue regarding illegal drug use, and whether or not drugs should be legalized, is one where I feel should rest largely with youth. As a 20 year old college student at the University of California, Berkeley, I have seen the effects that drugs harbor in a large community, on many disinherited individuals, on the family unit, and especially on a college campus. Youth offer a unique perspective and remind us that they will most greatly be affected by the policies shaped today that aim at improving tomorrow.

We know what drugs do to our body. Sound scientific research has shown that our current illegal drugs -- heroin, cocaine, methamphetamines, marijuana, LSD, and others -- have disastrous effects on our bodies. At the same time, social research has shown the effects that drugs have on our communities: the criminal element they very much quicken, the environmental disintegration their use enhances, and the feeling of helplessness they give to all in their way.

The youth of today have grown up in a generation -- the first of its kind -- where drug use was explicitly denounced and rejected. We have been led by parents, teachers, and other concerned individuals in thinking rightfully, that drug use is wrong, unnatural, and should be prevented. A concerted movement in the 1980's reduced drug use on all levels, taught my generation of the harms it entails, and even stopped the horrible statistic of the late 70's where people of my age were the only age group whose death rates actually increased, according to a guide put out by the American Psychiatric Press and Robert DuPont. Thus, this movement shaped attitudes, which in turn altered behavior.

However, as of late, many individuals and well-funded organizations have advocated policies that are a slippery slope towards destruction and away from any further progress. This outrages me. This outrages me that there are people out there claiming to care for my generation -- in light of understanding what drugs can do to a community and to an individual -- who support policies that accept its use as a natural part of growing up, just another element of being a "free" kid growing up in the land of liberty. Well that's wrong. And it's a sham.

Come to my school, in Berkeley, and you will see the crowning glory of something some called "harm reduction." Where organizations like the Drug Policy Foundation, fund groups like the Berkeley Cannabis Consumers Union, and the Cannabis Action Network. These organizations not only don't reject drug use, they claim its use is beneficial. Or the Drug Policy Foundation's funding of the needle-exchange and handout programs in the Bay Area. All part of something in a neat little package, that they call "harm reduction," that they define as, "reducing the harm that drugs do to an individual." But that any subjective, fair-minded individual would call drug legalization.

This isn't fair. It's not fair to my generation to be tricked with legalization euphemisms like harm reduction, or medicalization. It's not fair to the hundreds of thousands of individuals in this country that work day and night to help shape attitudes to stop its use. And it's not fair to youth as Americans, for, at their core, drug use threatens the root of democratic life and destroys any sense of liberty that will guide us to a brighter tomorrow.

Its been often said that our drug laws and strategy -- prohibition -- takes away from our rights as citizens. However, do we forget that our rights do come with responsibilities? The right to speak to someone cannot be divorced from the responsibility the speaker has in not being slanderous. The right to marry cannot be separated from the responsibility one spouse has on the other to not hurt them. Similarly, the right of freedom of expression, cannot be untied to the responsibility of being un hurtful to all. Drugs, however, rob us from any kind of sense of responsibility. We have no right to do them.

As a student from California, I have seen the disastrous effects that another trick had on my generation, when citizens legalized smoked marijuana for so-called medical purposes. I have sat and listened to hundreds of my peers talking to me about the merits of smoking pot, when asked where their information came from, they reply TV and from the media. Dr. James Fleming, Superintendent of a school district in Orange County, California noted that he had received a significant increase in the amount of marijuana offenses from school youth the first month after marijuana was legalized from November-December 1996. This is wrong, and it is shameful to our youth, to my peers, to the leaders of tomorrow.

Harm reduction is a policy with the words "inevitable" and "hopeless" etched deeply in its definition. I don't think drug use is inevitable. We have seen prevention work, and we know it can. So why then, on the brink of the 21st century, are we not united in a belief that drug use is harmful and that all should be done to stop its use? Why does this dialogue continue to occur? At this stage -- when many others and I have seen our best friends die from drugs, our sports stars fall to it, and our entertainment icons crumble because of it -- must we continue this?

If we truly want to lower the body count that drug use will stack up by the time my generation no longer makes up the young people in America but in fact composes our work force and leaders, we need to stand united in our belief that drug use is wrong and that it is our responsibility to prevent it. America's future generation of leaders deserves no less. For if we don't take this issue seriously and unite behind the science and common sense that guides our current drug policy, millions of new addicts and a new generation of drug abuse victims await.

Kevin Sabet is a 20 year old University of California Berkeley Junior. Majoring in Political Science and Public Policy, he comes to CADCA this summer as an intern for Policy Consultant Sue Thau. Having been involved in drug prevention since age 14, he is the Past President of IMPACT: Students Making A Difference, the nation's largest anti-drug coalition for youth. Currently he serves as the California Delegate to Drug Watch International, and is the Founder and President of Citizens for a Drug-Free Berkeley. He has submitted testimony to Congress and advised national anti-drug coalitions informally and as a member of many boards of directors, including advise to CNN, CBS, and the San Jose

Mercury-News, on subjects such as medical marijuana, drug legalization, and the importance of youth participation in drug prevention. In the Fall of 1999, he will begin his second term as a Senator for the Associated Students of the University of California (ASUC). He is also the Founder and President of International Students in Action, an arm of National Families in Action in Atlanta, Georgia.

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Mr. MICA. I am pleased now to recognize our ranking member on this side, who is the chairman of the International Relations Committee, the gentleman from New York, Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman.

I want to thank you for conducting what I consider to be a very important hearing today on this controversial issue of the legalization of mind-altering drugs. I also want to thank you for bringing some excellent witnesses, including General McCaffrey and Dr. Leshner and Mr. Marshall, our Deputy Administrator of the DEA, Mr. McDonough, Mr. Ehlers, Mr. Maginnis, Mr. Boaz and Ira Glasser. I think you have an excellent set of witnesses today that should help to focus our attention on this very important issue.

Legalization is virtually a surrender to despair. It cannot and should not be any topic of serious discussion in our Nation's debate on the challenges of illicit drugs. Hopefully by the time this hearing is over, we will make it clear that this is certainly not the direction in which any drug policy should be headed now, or ever.

Most importantly, we must not be perceived as sending mixed and confusing messages on illicit drug use to our young people. Illicit drugs are wrong, they are destructive, they are not recreational, they are deadly—nothing more, nothing less.

We have a firm, moral obligation not to lead our citizens into any spiral of despair and substance dependency through the legalization of mind-altering substances.

As Tom Constantine, our DEA Administrator, who is also a great cop and proven drug fighter, said so well at our November 1997, international antidrug conference in Scotland, "for those elites who proposed legalization, let them start in their own families and in their own school districts and then we can better evaluate this option."

Looking down from an ivory tower, it may be easy to throw up your hands and say it is time to surrender to the scourge of illicit drugs. But let those who offer such an unsophisticated solution, which avoids the hard choices and the difficult battles, first pass the Constantine home and school test if they want credibility in advocating legalization.

And for those who would despair in our fight against illicit drugs, let me state unequivocally that we can and we have made progress in fighting drugs in the past. Between 1985 and 1992, we reduced monthly cocaine usage in our Nation by nearly 80 percent, nearly an 80 percent reduction. There aren't many Federal programs that can claim that rate of success with such a difficult and a challenging problem as illicit drug use.

We made that kind of remarkable progress through a good public relations campaign, through Mrs. Reagan's Just Say No theme, and through a balanced, evenhanded supply and demand approach. Any balanced strategy in our Nation's drug war must include a reduction in both supply and demand and it must be simultaneous. By reducing supply, we have to eradicate the product at its source, we have to interdict when it gets into the mainstream of distribution, and we have to enforce when it reaches our shorelines, be able to arrest, convict and put away the drug traffickers. And in reducing demand, we have to educate our young people about the dangers of drug use, and we have to treat and rehabilitate the victims.

We have to do all of those things simultaneously. You can't take funding from one of those elements and give it to another.

I am looking forward to today's testimony. I hope that we may initiate the beginning of the end of this misguided and unfortunate debate about legalization. This debate detracts us from the important aspects of what we are trying to do, a debate that would take us in the wrong direction for both our Nation and our young people's future and well-being.

Mr. Chairman, I want to make certain that we refer in the record to DEA Administrator Tom Constantine's paper, as delivered in Austria this past January at another important international drug conference. DEA Administrator Constantine recounts as part of that excellent paper the impact of the de facto legalization of illicit drugs in the city of Baltimore. He stated that the strategy used in Baltimore was a lost strategy.

Chairman Mica, who participated in that Austrian conference, frequently cites the DEA Baltimore heroin figures. That startling data indicates that there exists one heroin addict for every 17 people in that nearby city.

Mr. Constantine's paper outlines the extensive devastation and adverse impact that heroin has had on the Baltimore community when it took a laissez-faire approach to the use of illicit drugs. Let no community follow Baltimore's example.

Mr. Chairman, I ask unanimous consent that Administrator Constantine's Vienna paper be included in the record of these proceedings.

Before closing, I would like to commend General McCaffrey for the outstanding job he has done in focusing attention on the drug war in our Nation and trying to elicit support for what our Nation should be doing to eliminate this very critical problem in our Nation.

Thank you, Mr. Chairman.

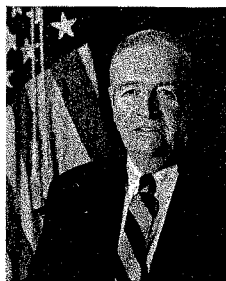
Mr. MICA. I thank the gentleman. Without objection, the paper that you referred to will be made a part of the record.

[The information referred to follows:]



International Drug Trafficking:
Law Enforcement Challenges for the Next Century
Thomas A. Constantine
Administrator of the
Drug Enforcement Administration
January 1999

Introduction: The problem posed by international drug trafficking syndicates affects many nations and is growing more complex every year. This paper outlines the history of organized crime involvement in narcotics trafficking and provides information on how American organized crime, and presently, internationally-based organized crime, have adversely affected the quality of life for millions of Americans and citizens of other nations throughout the past several decades. Recently, it has become evident that the international drug groups based in Colombia and Mexico have reached new levels of sophistication and have become a



Thomas A. Constantine
Administrator

threat not only to their own nations but to other nations in Latin America, the United States and Europe. Their power and influence are being witnessed on an unprecedented scale, and unless innovative, flexible and multi-faceted responses are crafted, these drug trafficking organizations threaten to grow even more powerful in the years ahead. While this paper concentrates on the law enforcement approaches that have been taken over the years to identify, target, arrest and bring to justice organized crime leaders, it is understood that many strategies—including prevention, education, treatment, diplomatic and political actions—must be taken to ensure that nations can successfully confront and repair the damage that international drug trafficking syndicates inflict on every nation they touch.

Key Points: This paper provides background information in a number of areas and makes the following points:

Organized Crime control of narcotics distribution: As a clear picture of American organized crime emerged during the 1950's and 1960's, it was evident that the five organized crime families in New York controlled much of the nation's heroin business. At that time, America's drug problem was limited to a relatively small number of individuals, many of whom lived in urban areas along the East Coast of the United States. During their heyday, American organized crime obtained heroin from their sources of supply in Europe and distributed it to retail markets in a number of communities. The organization's tight structure ensured that information on the extent of their involvement in the drug trade was closely controlled, and they routinely employed violence, intimidation and corruption to further their goals. Eventually, aggressive law enforcement strategies and tactics were designed and employed, particularly under the leadership of Attorney General Robert Kennedy, and these led to the dismantling of American organized crime. One main difference between the American organized crime and the international drug trafficking syndicates that followed was the fact that American organized crime carried out all of their activities on U.S. soil and they therefore were vulnerable to U.S. law enforcement activities. With the breakup of the French Connection, and with the emergence of the Colombian and other international organized crime syndicates as the predominant drug trafficking force from the 1970's to the present day, the American organized crime role in drug trafficking diminished.

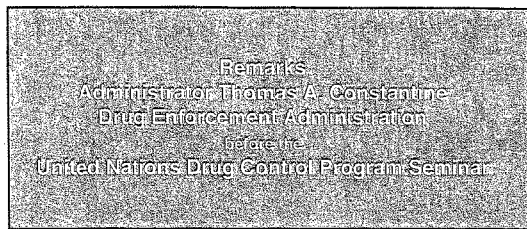
The rise of cocaine during the 1970's changed the American drug picture forever: During the 1960's, American attitudes and behaviors regarding drug use began to change dramatically. Only five percent of the population had tried drugs in the early 1960's and that percentage eventually rose to over 30% by 1979, when drug use levels were at their highest. When cocaine came onto the American scene, millions of people believed it was a benign drug that could be used recreationally. The introduction of crack cocaine on a national scale in 1985 ushered in an era of violence, addiction and hopelessness which corresponded to a period when violent crime rates increased over 50%, and murders increased by 31%.

The Colombian cocaine syndicates modeled themselves after American organized crime but were more powerful and ruthless than any of their predecessors: The Colombian groups controlled the cocaine trade from start to finish and their power and influence grew as the cocaine and crack epidemic took hold during the 1970's and 1980's. The Medellin organization established themselves as violent, ruthless drug traffickers who amassed a great fortune at the same time they terrorized Colombia. The Cali organization was more reticent about using the random violence that became the Medellin organization hallmark, but despite their outward demeanor of legitimacy, the Cali group also employed violence on a more specific basis—even in the United States—to intimidate or obtain retribution against rivals, public officials or other individuals. The Cali organizational structure was similar to American organized crime in its tight control of workers and compartmentalized hierarchy, but the Cali organization was far more powerful and sophisticated than any American organized crime families they emulated, with state-of-the-art communications systems, counterintelligence capabilities and transportation networks.

Organized crime groups from Mexico learned lessons from their Colombian predecessors and have assumed a great deal of power in their own right: Drug traffickers from Colombia forged an alliance with well-established poly-drug smugglers from Mexico during the late 1980's. This alliance, the arrest of the Cali leaders in 1995 and 1996, and the Mexico-based syndicates' emergence as major methamphetamine producers and traffickers all contributed to making the Mexico-based groups a major force in international drug trafficking. These organizations are wealthy and violent. Presently the criminal organizations based in Mexico represent the major challenge to victims of crime because of their power, their involvement in the eastward-spreading methamphetamine trade, and their propensity for violence.

The current heroin problem poses a major new threat to the United States: Independent traffickers from Colombia slowly and methodically began producing and trafficking high quality heroin to the United States in the early 1990's. Presently, they have surpassed all of their rivals from Southeast and Southwest Asia in U.S. heroin market share, and their savvy marketing techniques have resulted in a whole new group of heroin users in the United States. Many of these users begin smoking high purity heroin, believing that they will not become addicted; however, recent statistics indicate that many new heroin users have resorted to shooting up, and numbers of them are dying from overdoses.

Law enforcement solutions are effective in identifying, targeting and dismantling drug syndicates and reducing violent crime: Aggressive law enforcement has worked in the United States as is evident in the current diminished state of American organized crime. In Colombia, aggressive law enforcement activities resulted in the dismantling of the Medellin and Cali syndicates. Additionally, law enforcement officials in Italy and Thailand were aggressive in their sustained law enforcement targeting of the command and control mechanisms of organized crime groups, vividly illustrated by the diminished capacity of the mafia in Italy, and the arrest and extradition of several major heroin traffickers from Thailand to the United States. Given sufficient support and time, the law enforcement capabilities in Mexico should improve and lead to similar long-term results. Law enforcement has also had a tremendous impact on the levels of violent crime in communities around the United States; these levels have dropped dramatically in places like New York, Los Angeles and Houston, cities that were hardest hit by the crack epidemic and the proliferation of violent criminals during the past decade. Consistent, aggressive law enforcement is one of the most effective solutions to the problems posed by violent drug trafficking in the United States and in other nations.



I appreciate this opportunity to address the U.N. Drug Control Program Seminar today, and to speak with you on a number of topics that are critical to successfully addressing the complex narcotics problems which unfortunately plague too many of our nations. My comments today will focus on four central points which are woven throughout this presentation. First, that today's world has been transformed during the past thirty years due to rapidly advancing technology, transportation, communications, and political and economic shifts which are even more evident with the collapse of the Soviet Union; second, that the drug distribution problem in the United States, and increasingly, the rest of the world, is controlled by powerful international organized crime syndicates; third, that vigorous law enforcement can and does have a major impact on international organized crime and the international drug trade, when the top leadership of these international syndicates is targeted; and fourth, that law enforcement can and does have a major impact on the violence that has become so closely associated with organized drug distribution.

The American Mafia and Drugs Before 1970

Well before the advent of today's drug epidemic which has affected far too many American communities, American policy-makers were deeply concerned about the impact that organized crime was having on our nation. Over the last eighty-five years, the United States government has initiated a number of major studies or reviews to identify major organized crime groups and gain insight into how these organizations operated. The fact that organized crime controls the distribution of drugs has been substantiated by a number of U.S. Government studies.

During the 1950's, American interest in organized crime dramatically increased. Senator Estes Kefauver convened a Congressional committee in 1950 to investigate the links between interstate gambling and organized crime. During these hearings, the Senators noted that organized crime involvement was also evident in prostitution, drug trafficking, extortion and public corruption. In 1958, a clearer picture of organized crime emerged with the hearings sponsored by the Select Committee on Improper Activities in Labor. This committee was convened after the existence of organized crime, or the mafia, was confirmed by a New York State trooper, Edgar Croswell. Trooper Croswell located a meeting of mafia leaders in the upstate New York village of Appalachin where mob leaders met to discuss plans for greater involvement in the drug trade.

During 1963, Senator McClellan sponsored a series of hearings which clearly demonstrated that the American mafia was alive and well, had a defined structure and code of behavior. Joe Valachi, a low-level member of the mafia, testified about the details of his life in organized crime and presented a first-hand view of La Cosa Nostra. These televised hearings educated average Americans about the violence and intimidations used by the mafia to attain their goals.

The President's Commission on Law Enforcement and Justice, established in 1967, arrived at a definition of organized crime as a "society that seeks to operate outside the control of the American people and their Government. It involves thousands of criminals working within structures as large as those of any corporation." Despite the fact that this definition was written over thirty years ago, it still accurately describes the essential nature of organized crime today.

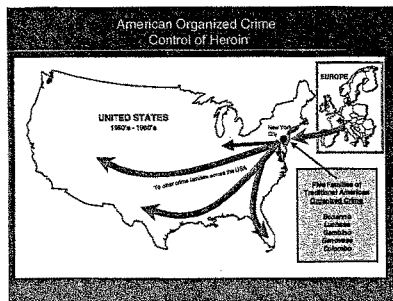
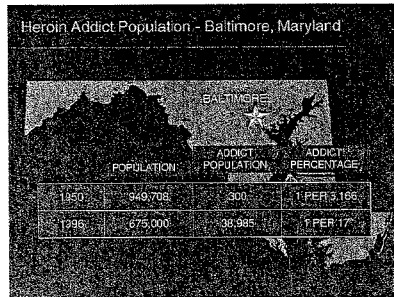
As Government commissions delved into the inner workings of the American mafia, millions of average people learned how the mafia was structured and how it operated. Critical to the success of the mafia was its tight structure: at the top level was a *boss*, or head of the family; next, an *underboss*; then a *consigliere*, or an advisor; then a *capo* who oversaw the day to day work of the organization; and then the *soldier*, who carried out the criminal activities of the group. The American mafia was controlled by twenty-four families, all of whom lived and operated within the United States. Their day-to-day activities included racketeering, prostitution, gambling, drugs, murders for hire, intimidation and protection rackets. To understand the scale of organized crime during the 1960's and 1970's it is important to note that New York's Genovese family included as many as twenty capos and 450 soldiers who carried out orders. Violence and intimidation were also a routine part of the mafia's inner workings, including the use of violence to protect their organization and target public officials for assassination.

The role of violence and intimidation were well-illustrated at the 1963 McClellan hearings and amplified twenty-three years later during the 1986 President's Commission on Organized Crime. In their final report, the commission wrote that: "Violence and the threat of violence are an integral part of the criminal group. Both are used as means of control and protection against members of the group who violate their commitment and those outside the group to protect it and maximize its power. Members were expected to commit, condone or authorize violent acts."

The Commission also noted the propensity for organized crime to breed corruption and flourish in an environment of corrupt officials. "Corruption is the central tool of the criminal protectors. The criminal group relies on a network of corrupt officials to protect the group from the criminal justice system. The success of organized crime is dependent upon this buffer, which helps to protect the criminal group from both civil and criminal government action." Violence, intimidation and corruption continue today to be essential tools used by international organized crime —particularly the international organized drug syndicates operating from Colombia and Mexico—to ensure their dominant positions in the world today.

The history of organized crime cannot be accurately told without a brief overview of the history of America's drug problem. Early on, reporting on American drug addiction was done at the federal, state and local levels by social service agencies. Gradually, federal law enforcement agencies became involved in reporting on addiction levels, and the Federal Bureau of Narcotics (FBN), a predecessor agency of the Drug Enforcement Administration gathered statistics on drug addiction during the mid 1950's. By 1957, the FBN estimated that there were over 44,000 addicts, although many experts believed the number was closer to 100,000.

A snapshot of the drug situation in Baltimore, Maryland in 1950 compared with 1997 illustrates how the scale of the drug problem has changed dramatically over the years. In 1950, Baltimore had 300 addicts out of a population of 949,708, meaning that one in 3166 individuals residing in Baltimore was a heroin addict. In 1997, 38,985 heroin addicts were reported in Baltimore, representing the fact that there is now one heroin addict for every 17 residents of Baltimore.



While the type of drug used by these drug addicts was not specified in FBN reporting, the predominant drug of choice at the time was heroin. And with the majority of addicts reported in the New York area, it is no surprise to learn that the five mafia families of New York controlled the heroin market in 20 major cities around the nation. Reporting on the heroin situation during the 1950's-1970's, the President's Commission on Law Enforcement in 1986 stated that: "the LCN (Cosa Nostra) controlled an estimated 95% of all of the heroin entering New York City, as well as most of the heroin distributed throughout the United States." New York's crime families obtained heroin from their Corsican sources who worked with French seamen to bring the heroin to the United States. Once there, it was distributed by the organized crime families to dealers working in low-income, minority communities.

Changes in the heroin trade between the 1950's and the late 1970's resulted in new sources of heroin available on the streets of the United States, and paved the way for the introduction of cocaine during the seventies. After the French Connection was broken, and the American mob's source of supply diminished, New York was no longer the main focus of drug trafficking activities.

In 1986, the President's Commission on Organized Crime reported that the mafia's monopoly on heroin distribution ended in 1972 "when under diplomatic pressure from the United States, Turkey banned opium production and the French Connection collapsed. Amsterdam replaced Marseilles as the center of European heroin traffic, and Chicago, Los Angeles, and Miami joined New York City as major U.S. distribution centers. Other trafficking groups rose to compete with the LCN for heroin dollars in New York City and throughout the country."

The Rise of Cocaine

When cocaine entered the American drug scene in the 1970's, no one predicted how this drug would change the nature and scope of the international drug trade forever. Societal changes in America during the 1960's prepared the way for this new drug epidemic; the prevalence of illicit drug use in the United States had increased dramatically in a short period of time. During the sixties, less than five percent of the population had an experience with illicit drugs. By the early 1970's, that percentage had doubled to over 10%, and by 1979, when drug use in America peaked with almost a third of the population having tried drugs during a lifetime, it was clear that millions of Americans viewed drug use as normalized behavior.

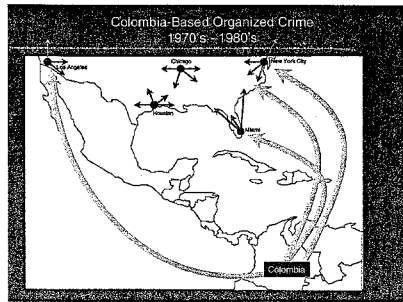
Prior to the 1960's American drug use was limited to specific segments of American society—artists, underworld elites, and individuals living on the edge of society. When cocaine was aggressively marketed during the 1970's as a benign, chic drug, Americans believed that it could be used recreationally without long-term consequences. Few people fully understood the addictive nature of cocaine and it was not until the crack epidemic in the 1980's played out that American society appreciated how dangerous and destructive cocaine really was.

Crack was first reported in California and Texas, and its abuse was considered a local problem until 1985 when it spread quickly to almost every state and its use had become a major national medical and law enforcement crisis. Crack was far more addictive than powder cocaine and was marketed as a low-price alternative to cocaine, making it readily available to poor people in urban and rural areas. It also created tremendous violence in the user and contributed significantly to the escalating crime rates and social problems which plagued America during the 1980's and early 1990's. Between 1984 and 1993, when the crack epidemic raged, violent crime in the United States increased over 50% and murders increased by 31%.

But the most dramatic change wrought by the introduction of cocaine to America in the last twenty five years was the rise of the international organized criminal syndicates from Colombia.

Organized Crime in the 1980's: Cocaine and the Colombian Mafias

At the epicenter of the modern drug trade, Colombian drug mafias thrived in an atmosphere of violence, intimidation and corruption. They took advantage of their country's geography to build an empire of unprecedented proportions. Close to Bolivia and Peru, where coca had been grown for centuries, Colombia had coastlines on the Pacific Ocean and the Caribbean Sea, giving traffickers ample routes to send their product to the United States. The first major cocaine



organizations to dominate the trade were based in Medellin, Colombia. The Medellin group, led by Pablo Escobar, Carlos Lehder, the Ochoa brothers and Gonzalo Rodriguez Gacha, was organized along the model of a multi-national corporation with regional cocaine manufacturing and distribution networks controlled by mid-level managers who transported cocaine to the United States and Europe by air, land and sea. These organizations also established complex international financial networks to launder their cocaine profits.

Violence and intimidation were also essential to the criminal enterprises of the Medellin group who employed an army of security forces to carry out acts of terror and assassinations. These private armies murdered hundreds of Colombian police officials, judges, journalists, and innocent people, including a Justice Minister and Presidential candidate. Two terrorist acts carried out by the Medellin group included the bombing of an Avianca airliner in 1989, which killed 110 people, and the bombing of the Department of Administrative Security (DAS) headquarters in December 1989, which killed 50 people and wounded 200.

Eventually, the Medellin cartel fell as its leaders were arrested or killed. Carlos Lehder was extradited to the United States in 1987 and Rodriguez Gacha was killed in a shootout with Colombian authorities in 1989. Extradition was outlawed by the Colombian Government in 1991 and soon after, the Ochoa brothers and Pablo Escobar surrendered to the Government to take advantage of the lenient sentences and prison conditions available to them. After a period during which Escobar ran his lucrative cocaine business from Envigado Prison, and after ordering the killing of a score of his associates, Escobar escaped from prison but was killed in a shootout with police in December 1993, after a lengthy manhunt by Colombian police officials.

As the Medellin cartel disintegrated, the Cali mafia quietly coalesced and assumed power equal to their predecessors.' Beginning as a loose association of five independent drug trafficking organizations, the Cali mafia employed many of the principles used by the traditional Italian mafia. Led by the Rodriguez-Orejuela brothers, Jose Santa Cruz Londono and Pacho Herrera, the Cali mafia was far more sophisticated than the Medellin group and eventually became deeply involved in all aspects of the cocaine trade, including production, transportation, wholesale distribution and money laundering. Whereas the Medellin group seemed to revel in the terror and violence that became their trademark—and ultimately contributed to their downfall—the Cali mafia attempted to avoid indiscriminate violence, further contributing to their image as legitimate businessmen.

However, when the Cali mafia employed violence to attain their goals—and they frequently did—it was precise and exacting. In the aftermath of the arrests of the Cali drug mafia leaders by the Colombian National Police in 1995, Cali assassins killed more than a dozen suspected government informants. They also used violence within the United States when necessary, as evidenced in the murder of the journalist Manuel de Dios Unanue, an outspoken critic of the Cali mafia who was murdered in Queens, New York in 1992. In May, 1996, John Harold Mena, who was in charge of the Cali mafia's New York operations testified in court that Jose Santacruz Londono had ordered de Dios' murder.

A key to the Cali mafia's success was its tight organizational structure. Their vast responsibilities and their intricate distribution networks in the United States necessitated that the Cali mafia rely on a sophisticated system which ensured maximum efficiency and minimal risk. Drug trafficking organizations from Colombia had always controlled the cocaine trade from top to bottom. Within South America, the Cali mafia, and before them, the Medellin group, depended upon the acquisition of tons of coca products from Bolivia and Peru which was then converted into cocaine HCl, generally in Colombia. These labs in Colombia ranged from simple labs to complex compounds where it was possible to produce up to one metric ton of cocaine per week.

The mafias also devised ingenious ways to deliver tons of cocaine to the United States and Europe over the years. Routes and techniques have been refined during the past several decades, and today over half of the cocaine entering the United States is shipped from Colombia through Mexico. Currently, maritime vessels are the primary means used by traffickers to smuggle cocaine from South America to Mexico, using the Pacific or Caribbean routes; traffickers are also using the highways of Central America to transport tons of cocaine from Colombia into Mexico. For a period of time, it was customary for traffickers from Colombia to ship metric ton quantities of cocaine into Mexico by plane but that method is less common at the current time. Once the cocaine is safely delivered to traffickers in Mexico, independent Mexico-based transportation groups subcontracted by the Colombian trafficking organizations arrange for the delivery of the cocaine to contacts within the United States.

Colombian Mafia Structure Within the United States

During their heyday, the Cali mafia also relied on a complex distribution network within the United States, and the system they set in place is still being used on a daily basis in many major U.S. cities. Using an intricate system of “cells” within the United States, the Colombian trafficking groups set up a presence in a number of geographic areas. Using the cell model employed by international terrorist organizations, the Colombian mafias carry out specialized functions such as the storage of cocaine, transportation, communications, money laundering, security, wholesale distribution, personnel and inventory, which are all handled by employees of the cell. Each cell employs between 10-25 individuals who operate with little or no knowledge about the membership or responsibilities of other cells carrying out tasks within the same or other cities.

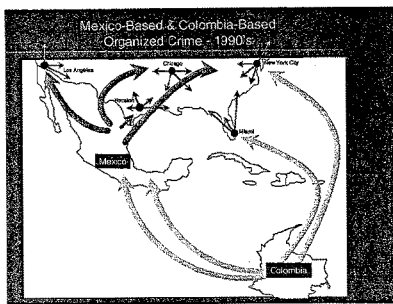
Typically, the head of each cell reports to a regional director who manages several cells. This regional director, in turn, reports directly to one of the major drug lords of a particular organization or their designee, based in Colombia. Characterizing the way these groups operate is a rigid, top-down command and control structure where trusted lieutenants have day-to-day operating responsibilities, with the ultimate power residing in those leaders in Colombia. Upper echelon members of these cells are generally family members or long time associates who have gained the trust of the handful of mafia leaders running the empire. The cell heads are typically recruited for the mafia’s overseas assignments from the criminal “talent pool” in the syndicate stronghold cities of Cali, Medellin or Bogota. The cells are also comprised of other trustworthy individuals from Colombia, the Dominican Republic or Cuba, for instance.

Because the mafia bosses are headquartered overseas, it is necessary for them to establish a workable communications system which protects the content of their communications and provides operatives with enough information to accomplish specific tasks. The cell members report on a daily basis to their bosses in Colombia using cellular phones, faxes, pagers and other communications methods. Additionally, the drug lords have employed an aggressive counter-surveillance system to thwart law enforcement including the use of staged drug transactions on communications devices they believe are monitored; limited-time use of cell phones and pagers (generally 2-4 weeks); calling cards and encrypted communications devices.

The Colombian trafficking groups have traditionally concentrated their activities on the wholesale drug distribution level and have employed an army of operatives within the United States to distribute drugs on a retail basis. Criminals from diverse ethnic groups including Dominicans, Mexicans, Cubans, Jamaicans, as well as African Americans, are used by Colombian drug bosses to distribute cocaine, crack, and now heroin. The groups involved in drug retailing—including established gangs such as the Crips, the Bloods and Jamaican “posses”—are those groups predominantly responsible for the violence and murders that characterize the crack trade within the United States.

The Rise of Organized Crime Groups from Mexico in the 1990's

The influence and power of organized crime groups from Mexico, fueled by the enormous profits generated by their involvement in the drug trade, has increased significantly over the past several decades, and were bolstered by the involvement of Mexican groups in the cocaine distribution business during the late 1980's and 1990's. When law enforcement attention and activity increased in the Caribbean and South Florida area during the 1980's, cocaine traffickers began using Mexico as a conduit for U.S.-based cocaine shipments. Because traffickers from Mexico had established themselves as capable poly-drug smugglers over the years, Colombian trafficking organizations found a solid transportation infrastructure and ample expertise to assist them in getting their drugs to market.



By the late 1980's, an estimated 50-70% of the cocaine available in the United States entered through Mexico. Today, Mexico remains as the primary corridor for cocaine, and now methamphetamine. Beginning in the late eighties and evolving into the 1990's, the role of traffickers from Mexico began to change dramatically as traffickers from Colombia began to pay Mexico-based transporters in cocaine—sometimes as much as half of the load—rather than cash as compensation for their transportation services. Organized crime figures from Mexico began using their long-established contacts to emerge as major cocaine traffickers in their own right, especially after the arrest of the Cali mafia leaders in 1995. Today, the U.S. cocaine market is divided, with traffickers from Mexico dominating cocaine markets in the West, and increasingly, in the Midwest. Groups from Colombia and the Dominican Republic still control cocaine trafficking along the East Coast of the United States, although there are recent indications that traffickers from Mexico are becoming deeply involved in cocaine trafficking to places like New York. In the last two years, Mexican cells within the United States have grown in size and influence and are expanding their power in cocaine markets long dominated by Colombians, such as New York and Chicago.

In addition to gaining a prominent role in cocaine trafficking during the early 1990's, traffickers from Mexico, who had always been skilled in the production and trafficking of numerous drugs, committed themselves to large-scale methamphetamine production and trafficking during this same period. Methamphetamine, which had appealed to a relatively small number of American users, re-emerged as a major drug of choice during the mid-1990's. Traditionally controlled by outlaw motorcycle gangs, methamphetamine production and trafficking was now being entirely controlled by organized crime drug groups from Mexico, operating in that country and in California.

Statistics demonstrated that methamphetamine use and availability had dramatically increased in a short period of time. The Drug Abuse Warning Network (DAWN) indicated that emergency room episodes involving methamphetamine increased from 4900 in 1991 to 17,400 in 1997, an increase of 280%. The areas hardest hit by the meth epidemic were Dallas, Denver, Los Angeles, Minneapolis, Phoenix, San Diego, San Francisco and Seattle. Concurrently, law enforcement seizures of methamphetamine and methamphetamine laboratories were also increasing. Seizures along the Southwest Border, the epicenter of the trafficking activities of organizations from Mexico, increased from 7 kilograms in 1992 to almost 1400 kilograms in 1998. During the same period of time, seizures of methamphetamine transported by Mexican nationals on U.S. highways increased from 1 kilogram in 1993 to 383 in 1998.

At the present time, methamphetamine trafficking and abuse are spreading across the United States at an alarming rate. With their primary methamphetamine production headquartered in remote areas of California, the surrogates of Mexican organized crime groups are also establishing a presence in cities in the Midwest, the deep South and the East Coast in order to further their business goals.

Organized criminal groups from Mexico have not yet joined together and evolved into a monolithic entity like the Medellin group or the Cali mafia. Several powerful and violent organizations exist and operate today from headquarters in a number of Mexican cities. The Carillo Fuentes organization out of Juarez remains one of the most powerful of the Mexican organized crime families despite the death of its leader, Amado in 1997. The Tijuana Cartel, also known as the Arellano Felix organization, operates in Sinaloa, Jalisco, Michoacan, Chiapas and Baja California. This violent group orchestrates the shipment of multi-ton quantities of cocaine and marijuana to the United States, and is also responsible for heroin and methamphetamine production and trafficking. Assassins on the payroll of this organization operate on the streets of San Diego and are responsible for many violent activities in Mexico and the United States.

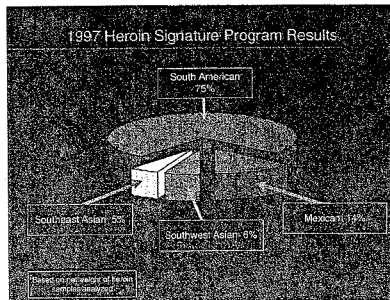
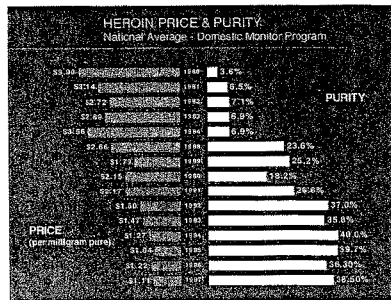
The Amezcua brothers are major methamphetamine producers and traffickers, relying on their expert smuggling skills to obtain vast quantities of the precursor chemicals necessary for large-scale methamphetamine production. The other major narcotics organized crime family operating in Mexico today is the Caro Quintero organization out of Sonora, Mexico. They are responsible for marijuana production and smuggling, as well as heroin and cocaine trafficking. Most of the major organized crime narcotics traffickers in Mexico today have been indicted within the United States for their involvement in cases or seizures in the U.S.

Like the mafia groups from the United States and Colombia that preceded them, organized crime syndicates from Mexico are extremely violent and routinely employ intimidation and the corruption of public officials to achieve their objectives. There have been numerous incidents which illustrate the ruthlessness of these organizations, including the recent gangland-style massacre of 22 people in Baja California Norte carried out by rival drug traffickers this past September.

Heroin's Re-emergence in the United States

Heroin did not disappear from America when the mafia's Corsican supply of heroin was eliminated in 1972. Over time, other sources of supply emerged from Southeast Asia, Southwest Asia and the Middle East and the American mafia continued to distribute heroin to users mostly concentrated in major cities.

However, the current heroin problem that has emerged in the United States is controlled not by American organized crime, but by a new group of international organized crime figures from Colombia. In much the same way that their Medellin and Cali predecessors ensured their dominance over the cocaine trade in the 1980's, heroin traffickers from Colombia are employing savvy marketing concepts to successfully rebuild American users' interest in heroin.



Beginning in the early 1990's, independent traffickers from Colombia began to supply retail level outlets primarily in the Northeast United States with high quality, pure heroin. Colombian traffickers had spent several years cultivating opium and refining their heroin production capabilities, positioning themselves to take advantage of a gradually diminishing crack market. By supplying dealers with high purity heroin to give away as free samples, and by establishing "brand names" to garner customer loyalty, Colombian traffickers quickly gained a foothold in the burgeoning heroin market in cities such as New York, Boston and Philadelphia. They also began using Puerto Rico as a major transit area to distribute their product to places such as Florida and New Orleans. Colombian heroin was also more attractive than competitors' supplies because of its low price—\$75,000 per kilo in New York City—and its extremely high purity.

Through a variety of programs DEA has had in place over the years, the dominance of Colombian heroin was confirmed. In 1997, 75% of the heroin seized and analyzed by federal law enforcement came from South America; in 1989, 88% of the heroin analyzed was of Southeast Asian origin.

The Law Enforcement Response

America's long experience with organized crime over the decades necessitated the development and execution of an aggressive strategy to identify, target and incapacitate the leadership of these organizations. During the 1960's, Attorney General Robert Kennedy intensified law enforcement efforts aimed at the mafia, and the successful result of this approach is evident in the current diminished state of the American mafia today. By establishing a program of nation-wide strike forces and sophisticated investigative strategies that ultimately broke the "code of silence" which protected mafias for so long, and by attacking the command and control of mafia organizations, U.S. law enforcement since the 1960's has successfully addressed the organized crime problem which had threatened America for decades.

DEA employs a similar, aggressive strategy against the leaders of international organized crime groups who are responsible for the distribution of narcotics into and within the United States. One key difference between this strategy and the one that guided law enforcement's efforts to dismantle the American mafia is a recognition that the leadership of today's international drug syndicates reside and operate in foreign countries. The American mafia leaders carried out all of their operations on U.S. soil and lived in American cities and communities, vastly enhancing the capabilities of U.S. law enforcement to ultimately apprehend them and bring them to justice.

DEA's approach is threefold. First, attack the principal leadership of these international organized crime syndicates who operate outside of our geographical boundaries by building solid cases against them and indicting them, often repetitively, in U.S. jurisdictions. Second, attack the surrogates of these international drug lords who operate on U.S. soil, represent the highest levels of the command and control structure of these organizations and are responsible for carrying out the orders of their bosses. And third, attack the leaders of the domestic gangs who distribute drugs in local communities and are responsible for the vast majority of the violent crimes that are associated with their drug activities.

Accomplishing these goals is possible when a variety of investigative tools are used and when U.S. law enforcement officials have a sound and productive working relationship with their foreign counterparts. Within the United States, DEA employs complex wiretap and other communication intercept investigations to identify these organizations at all levels, and to obtain actionable information which can lead to the dismantling of these organizations. Drug seizures are also exploited to their fullest potential by gathering information gleaned during controlled deliveries that further identify important cell members and their modes of operation. Additionally, complex long-term conspiracy investigations are conducted to gain critical information on the way these organizations operate and to build solid cases against the leaders of these syndicates who presume they are "untouchable." Close coordination with other law enforcement entities within the United States and with foreign law enforcement counterparts also greatly enhances the potential and actual success of these investigations.

By employing the abovementioned strategy, it has been possible for DEA and numerous law enforcement partners around the world to achieve many notable successes. One recent example is the successful cooperative working relationship between DEA and the Colombian National Police (CNP) which led to the arrest and incarceration of the top leadership of the Cali mafia in 1995 and 1996. As has always been the case with organized crime, the Cali mafia members attempted to repeatedly thwart law enforcement's efforts to apprehend them through intimidation and corruption. Key workers within Cali cells in the United States were under real threats of violence and possibly murder if they cooperated with law enforcement in any way, a point that was illustrated by a Colombian job application that was seized by DEA during a raid in New York. The application specified the need for the applicant to list relatives living in Colombia in a clear attempt by the Cali mafia to gain human collateral to hold against their workers in the United States.

While the difficulties faced by law enforcement to dismantle the mafias in the United States and Colombia seemed almost insurmountable at times, they pale in comparison to those faced in current efforts to bring the leaders of Mexican organized crime groups to justice. Today's international organized crime groups based in Mexico are extremely powerful, involved in a variety of diverse drug trafficking activities, and have closer geographic proximity to the United States than did their Cali mafia counterparts. The infiltration of criminals from Mexico into numerous U.S. communities, including areas where organized crime does not usually operate, further complicates the problem.

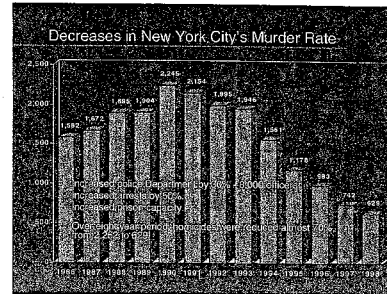
The criminal organizations in Mexico have become increasingly more powerful over the past five years. The Government of Mexico, after having determined that trafficking organizations had compromised virtually all of that nation's civilian law enforcement organizations, directed that the Mexican military would assume responsibility for targeting drug trafficking organizations until critical improvements in the law enforcement organizations could be made. Government of Mexico officials have stated that it will take years for Mexican institutions to gain the professionalism and integrity necessary to mount an all-out assault on organized crime and drug trafficking organizations operating in that nation. The obstacles facing law enforcement are enormous in Mexico: traffickers are used to operating in an environment where drug traffickers routinely intimidate, bribe and corrupt officials, making it very difficult for law enforcement in the United States to confidently share information without the potential for compromise.

There have been intensified attempts to improve the present situation facing U.S. and Mexican law enforcement, including the formation of specially trained and well equipped teams that have been screened to ensure the highest degree of integrity. However, to date, these initiatives have resulted in limited success and progress has been disappointingly slow.

Despite these obstacles, DEA believes that the application of aggressive law enforcement principles and techniques is the most successful way to dismantle international organized crime syndicates. Within the last several years, it has become very clear that the recent reductions in the violent crime rate within the United States —now at levels not seen since the 1960's—are due to aggressive law enforcement at all levels.

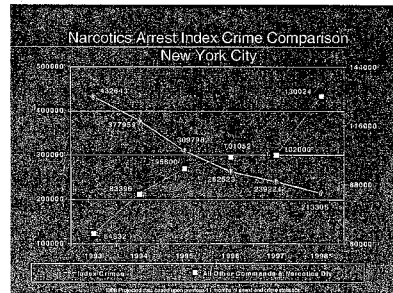
The New York City example is perhaps the most compelling illustration of this point. In the early 1990's, after three decades of rapidly increasing levels of violent crime which were exacerbated by the crack epidemic, the City of New York embarked upon an ambitious program to enhance its law enforcement capabilities. In this instance, public opinion played a large role in galvanizing support for tougher law enforcement after a 22 year old tourist from Utah was killed in a Manhattan subway while trying to protect his parents from thieves. The political leaders of the city and the state came together to determine how

best to turn the terrible tide of violent crime around. City leaders increased the police department by 30%, adding 8000 officers. Arrests for all crimes, including drug dealing, drug gang activity and quality of life violations which had been tolerated for many years, increased by 50%. The capacity of New York prisons was also increased. The results of these actions were dramatic: the total number of homicides in 1998—629—was less than the number of murders recorded in 1964. Over an eight year period the number of homicides was reduced from 2262 to 629—a reduction of almost 70%.



DEA has also been aggressive in developing and implementing programs to reduce violent narcotics-related crime. One enforcement program, the Mobile Enforcement Teams, lends support to local and state law enforcement agencies that are experiencing problems arising from violent drug related crime

in their communities. The results of this program over the past four years indicate that aggressive enforcement of drug laws does have a lasting impact on reducing crime and improving the quality of life for residents of communities across the nation. Statistics indicate that on average, communities participating in the MET program have seen a 12% reduction in homicides.



Aggressive law enforcement that targets the command and control of organized crime groups and neutralizes mafias' abilities to intimidate and corrupt, has worked in the United States and in Colombia, as was mentioned previously. There are other countries where this is also true. In Italy, experts

proved that aggressive law enforcement was the most effective tool in Italy's efforts to eliminate the mafia. The Government of Thailand also demonstrated the value of sustained law enforcement efforts when the top leadership of the Shan United Army, Khun Sa's powerful and until then "untouchable" heroin trafficking organization, was arrested in 1994. Several members of this leadership were extradited to the United States where they faced justice for their crimes.

Conclusion

The problem of organized criminal syndicates' involvement in narcotics trafficking is now facing many governments and societies. The international criminal organizations operating on a global basis today represent the gravest criminal threat that our nations have ever faced at any time during our history. But history has also taught us that consistent, aggressive law enforcement can and does work when coordinated resources and will are focused on eliminating the command and control structure of these organizations, and eliminating the environments of intimidation, corruption and violence which allow these organizations to flourish.

In the coming decades, it will be critical for all of our nations to make a strong commitment to use all of the tools available to us to fight international criminal organizations as they become more deeply involved in the global narcotics trade. It is important for us as we craft our response, to ensure that we match the traffickers' flexibility and resources to enhance our potential for success. During the coming years, it will be necessary for governments to marshal the resources and expertise of diplomats, political leaders and opinion makers in our mutual efforts to rid our nations of the evil influences of organized criminal narcotics trafficking syndicates.

Mr. MICA. I am pleased now to recognize for an opening statement the gentleman from Maryland. I was going to say the gentleman from Baltimore, but after the comments from the gentleman from New York, I thought I should cool it. Thank you.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. I certainly am from Baltimore, and I am very proud to be so.

As I listened to the gentleman from New York, I could not help but think about the fact that there are so many people who need medical treatment. They need treatment. For a lot of people, it is very easy to sit back and look at folks. Well, I live in the middle of it. I live in a drug-infested neighborhood. I know people who have been trying to get treatment for years—for years—and can't get it.

As a matter of fact, General McCaffrey came to Baltimore about 2 years ago and went through one of those neighborhoods in east Baltimore and had an opportunity to see young men and women who were struggling, taking their own resources, coming up with innovative ways to get the funds to treat themselves. So I think we have to be very, very careful when someone sits at a distance and then tries to put a microscope on any community and still complain but don't provide the funds to address the problem.

The problem is very serious. It is one, as I said before, I count as a top priority on my list since I live with it. I have known the little girls who I have watched grow up from babies and now selling their bodies for \$5 at 14 years old. I see them every day. I know the pain of coming home and seeing my home ransacked, my car broken into because people are in so much pain they don't even know they are in pain.

I am glad that we are having this hearing today. I am personally against decriminalization of drugs, but I am for making sure that people are treated. I am glad that General McCaffrey has made the efforts he has made with regard to inmates, people going to jail and coming out worse off than when they went in. At least we are beginning to try to deal with that problem so when they come out they are better off.

The fact is, sometimes this whole problem reminds me of my little girl when she was a little younger—she is 5 now, but when she was a little younger, she was about 2 years old, I guess, she would come up to me and say, "daddy, let's play hide and go seek," and she would put her hand up to her face and say, "daddy, you can't find me." But she was standing right in front of me.

What I am trying to say is that so often the solutions to the problems are right in front of us, but we don't address them for various reasons. And sometimes I think—I think it was Martin Luther King, Sr., who said, you cannot lead where you do not go, you cannot teach what you do not know. I would ask some folks to do what General McCaffrey has done, to walk in my neighborhood, to see what happens when children are left out and left behind, to see that babies do grow up and are placed in difficult circumstances.

And so, no, decriminalization is not the solution. Legalization is not the solution. The solution is that we must have a more humane society so that people don't grow up feeling that they have to do these things. And, second, if they do these things, to make sure

that they get appropriate treatment so that they can come back to a life that is productive and a life that is meaningful.

I look forward to the testimony, Mr. Chairman, and I want to thank you for holding this hearing. I am just so anxious to hear what is going to be said, I just don't know what to do.

With that, I want to thank all of our witnesses for being here and thank you for taking your time.

I would remind our witnesses—I am almost finished, Mr. Chairman—I would remind our witnesses that your testimony is so important to us. This is the Congress of the United States of America, the greatest country in the world, the most powerful country in the world; and we so happen—we folks up here have been charged with leading this country. Your testimony helps us to address the policies that make this country the great country that it is. We simply take time out to say thank you.

Mr. MICA. I thank the gentleman.

I now recognize the gentleman from Arkansas for an opening statement, Mr. Hutchinson.

Mr. HUTCHINSON. Thank you, Mr. Chairman.

I want to welcome General McCaffrey. I look forward to your testimony.

General, I want to express that I have enormous respect for you and the work that you have done, the commitment that you have made to this endeavor and to your work. I can't think of any public official that puts his heart more into the job that you are trying to perform than you do, and our country should be grateful to you.

We do have some, I think, differences in emphasis. I have read your testimony. I think that when you talk about a fallacy, it being a fallacy that we are fighting a war on drugs, and that the reality is that it is analogous to the fight against cancer, you have some legitimate points, I guess, that you don't want to declare war on your citizens and whenever someone goes out to make a drug arrest, you don't want to treat it like a war. Those points are well-taken; and, obviously, there is some merit to that.

But, to me, as a parent of teenagers, and I have had family members that have struggled with drugs, it is a war in a family, I guarantee you, and it is a war in our society. You document that through your testimony, which is a very strong statement as to why we should not legalize marijuana in our country. So I guess you can use whatever term—it just doesn't make any sense to me to make a big issue out of the contention that the terminology of "war against drugs" is wrong. This is not something I want to live with in America's families.

Second, and I hope you will address some of these issues, because I am not aware of all that you are doing, but this legalization of marijuana across the country is of enormous concern, the initiatives in the various States. Please explain specifically what the administration is doing in each of these States to combat these efforts. It would appear to me that the media campaign budget is extraordinarily—generous is not the right word—but hefty and should be targeted toward these States and not just necessarily an antidrug message but a specific message that relates to the problems in legalization that you have articulated so well in the testimony that I have reviewed.

And also I just think it takes your presence and the presence of the Attorney General of the United States in each of these States holding news conferences, outlining the problems that you have recited and urging people not to be swept away with this legalization effort. And so please comment on what you are doing, what the administration is doing, and what the Attorney General is doing in that regard.

Then, finally, in looking at the goals of your 1999 strategy, certainly you can't disagree with those goals, I mean, they are very important. The education is critically important, obviously the key component of any campaign, reducing crime, social cost, the interdiction efforts. It just, at least in overall goals, it seems like there is not a strong enough law enforcement component. Are these goals different from previous years in regard to the law enforcement component and the emphasis upon law enforcement? If you could comment on that and advise me if there is any change or retreat from the hard push in the law enforcement arena.

With that, I will yield back; and I look forward to your testimony, General McCaffrey.

Mr. MICA. I thank the gentleman.

We have no further opening statements at this time.

As you know, General, this is an investigation and oversight subcommittee of Congress. We swear in all of our witnesses. So if you would stand, sir and raise your right hand.

[Witness sworn.]

Mr. MICA. Welcome, General. We won't put the time clock on you today. You are the only one on the panel. Welcome back. We look forward to your testimony. Without further ado, sir, you are recognized.

**STATEMENT OF GENERAL BARRY R. MCCAFFREY, DIRECTOR,
OFFICE OF NATIONAL DRUG CONTROL POLICY**

General MCCAFFREY. Thank you, Mr. Chairman, to you and Congresswoman Mink and all the members of your committee.

The enormous amount of energy that all of you collectively and individually have poured into this. I have watched your travels around the country, the two of you on your trip to the Andean ridge, and I thank you for your engagement on the issue and indeed for your guidance and support over the last several years.

Let me say that some of the witnesses who are here to support your hearing, particularly Dr. Alan Leshner, without meaning to embarrass him, I consider a national treasure. You gave him a half billion dollars last year in research money. You have increased his budget by 36 percent in 4 years. He knows what he is talking about. That research has been the basis of an informed policy on drug abuse in America that has guided our efforts over the last several years.

You also have Donnie Marshall here, representing Tom Constantine and the 9,000 men and women of the DEA. Thank God for their integrity and for the skill with which they have confronted this international and implacable drug criminal threat that we face. I look forward to hearing what Donnie says. He has a ton of common sense, and the DEA and counternarcotics officers who are present understand drug abuse at face value.

Bob Maginnis, from the Family Research Council, has been a very important NGO and a voice of common sense; and we thank him for his writing and thinking and influence.

And Jim McDonough, my former head strategic planner, now working for Governor Jeb Bush, we look forward to his comments.

Mr. Chairman, I thank you for allowing me to have the opportunity to bring together these witnesses and listen to the people that have really formed and guided our own efforts.

Sue Thaug is here from the Community Antidrug Coalition of America. There are more than 4,000 coalitions around the country. Thanks to the Portman-Levin bill, we are now growing the number of community coalitions—Johnny Hughes from the National Troopers Coalition, Bill McGiveney from DARE. There are 26 million American children involved in the biggest drug prevention program in the world. There are now 9 million plus kids in the international arena. It is spreading throughout Latin America. A lot of the teaching of the DARE coordinators is going on in Costa Rica.

With your permission, Mr. Chairman, he has brought some of his kids here, and they may sort of provide an underpoint, if I could ask them to stand up. How about these DARE kids? Go ahead. Stand on up.

Dr. Linda Wolf Jones, Therapeutic Communities of America, is here to again key off Congressman Cummings' point. We are not going to solve this problem until we understand that there are 4.1 million Americans who are chronically addicted to illegal drugs. We will go on to talk about this, if you wish, but at the end of the day, we believe we have probably half the infrastructure we require to bring effective drug treatment to bear on that problem. We thank Dr. Wolf Jones for her leadership.

Wes Huddleston is here, Director of the National Drug Court Institute. What a concept. Four years ago, there were a dozen drug courts. Today, there are more than 600 either online or coming online this year. The first national convention was 5 years ago. There were less than 300 people there. This year it was in Miami. There were more than 3,000 people there from all over America.

Jessica Hulsey is here, the youth member of our Drug Free Communities Advisory Board.

We are very grateful the YMCA has Eden Fisher Derbman here, they have tremendous program engagement with young people.

I thank Christie McCampbell, the president of the California Narcotics Officers Association for being here. The National Narcotics Officers Association has been an extremely influential body in helping form our own thinking.

Let me also, mention Rob Connelly, Boys and Girls Clubs of America, for their tremendous work. They are supported by Congress and by many municipal governments in pulling on-line literally 1,000 plus boys and girls clubs. This is one of the most effective concepts I personally know of in the field of drug prevention.

Let me, if I may, Mr. Chairman, draw attention to the statement which Congressman Hutchinson was generous enough to refer to. We put an enormous amount of work into this thing.

I thank you for this hearing which really formed the basis of us going to the administration, going to our stakeholders and saying, "Let's form a written response to not just the drug legalization

community but those who have disguised themselves under other terms to advance that argument." I would hope that this statement, which is cleared by the administration, will stand as a position paper to guide our future discussions.

Mr. MICA. Excuse me. I think we would ask unanimous consent that statement be inserted as part of the record at this time.

General MCCAFFREY. Yes, that would be a useful addition to the record.

Mr. MICA. Without objection, so ordered. Thank you.

[The prepared statement of General McCaffrey follows:]



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

TESTIMONY OF BARRY R. McCaffrey
DIRECTOR, OFFICE OF NATIONAL DRUG CONTROL POLICY
BEFORE THE HOUSE GOVERNMENT REFORM AND OVERSIGHT COMMITTEE
SUBCOMMITTEE ON CRIMINAL JUSTICE,
DRUG POLICY, AND HUMAN RESOURCES
THE DRUG LEGALIZATION MOVEMENT IN AMERICA
June 16, 1999

Chairman Mica, Congresswoman Mink, thank you for the opportunity to testify before you today on the drug legalization movement in the United States. Before discussing this issue, on behalf of the Office of National Drug Control Policy (ONDCP) allow me to thank the leadership and members of this Subcommittee for the strong bipartisan support you have provided to our *National Drug Control Strategy*. With your help we are making substantial progress in reducing the threat of illegal drugs to our nation.

INTRODUCTION

Given the negative impact of drugs on American society, the overwhelming majority of Americans reject illegal drug use. Indeed millions of Americans who once tried drugs now turn their backs on them -- they no longer "do drugs," and most importantly, don't want their children doing them. While most Americans steadfastly reject drugs, small elements of the social spectrum argue that prohibition -- and not drugs -- creates the problems we face. These people offer solutions in various guises, ranging from outright legalization to so-called "harm reduction." In fact, all drug policies seek to reduce the harms of drug use. No rational approach would seek to increase harms to families, children and our nation. The real question is: what policies actually do the most to decrease the harms drugs cause?

Part I of this testimony provides an **overview** of what proponents of **legalization** really want to achieve through their efforts, namely: legalization of not only marijuana, but other more dangerous drugs such as heroin and cocaine. **Part II** of this testimony cuts through the haze of this misinformation to **expose the fallacies and realities** of what **legalization** would mean to this nation, namely: significantly higher rates of drug abuse, particularly among young people, and exponentially increased human and social costs to our society. **Part III** of this testimony sets out the **balanced approach** to fighting drugs provided in our *National Drug Control Strategy*. This part summarizes how we intend to reach our goal of cutting drug use and its consequences in America by half over the next ten years.

I. WHAT PROPONENTS OF LEGALIZATION REALLY WANT: EASY ACCESS TO ALL DRUGS OF ABUSE

Our nation's democratic system of government is founded upon free and open debate. Our nation holds no beliefs or icons above challenge and examination. We all must be willing to lay the facts and our analysis on the table of public scrutiny, and make the case for what we believe.

However, in the marketplace of ideas, just as in other marketplaces, there are people willing to use deceptive claims, half truths and flawed logic to hawk ill-considered beliefs. Nowhere is this problem more clear than with respect to the drug legalization movement.

Proponents of legalization know that the policy choices they advocate are unacceptable to the American public. Because of this, many advocates of this approach have resorted to concealing their real intentions and seeking to sell the American public legalization by normalizing drugs through a process designed to erode societal disapproval.

For example, ONDCP has expressed reservations about the legalization of hemp as an agricultural product because of the potential for increasing marijuana growth and use. While legitimate hardworking farmers may want to grow the crop to support their families, many of the other proponents of hemp legalization have not been as honest about their goals. A leading hemp activist, is quoted in the *San Francisco Examiner* and on the Media Awareness Project's homepage (a group advocating drug policy reforms) as saying he "can't support a movement or law that would lift restrictions from industrial hemp and keep them for marijuana."¹ If legalizing hemp is solely about developing a new crop and not about eroding marijuana restrictions, why does this individual only support hemp deregulation if it is linked to the legalization of marijuana?

Similarly, when Ethan Nadelmann Director of the Lindesmith Center (a drug research institute), speaks to the mainstream media, he talks mainly about issues of compassion, like medical marijuana and the need to help patients dying of cancer. However, Mr. Nadelmann's own words in other fora reveal his underlying agenda: legalizing drugs. Here is what he advocates:

*Personally, when I talk about legalization, I mean three things: the first is to make drugs such as marijuana, cocaine, and heroin legal . . .*²

¹Katherine Seligman, *Legalization Sought for Cousin of Pot*, San Francisco Examiner, May 9, 1999, C1 (quoting hemp activist Jack Herer).

²Ethan Nadelmann, *Should Some Drugs Be Legalized?*, 6 Issues in Science and Technology 43-46 (1990).

*I propose a mail order distribution system based on a right of access*³

*Any good non-prohibitionist drug policy has to contain three central ingredients. First, possession of small amounts of any drug for personal use has to be legal. Second, there have to be legal means by which adults can obtain drugs of certified quality, purity and quantity. These can vary from state to state and town to town, with the Food and Drug Administration playing a supervisory role in controlling quality, providing information and assuring truth in advertising. And third, citizens have to be empowered in their decisions about drugs. Doctors have a role in all this, but let's not give them all the power.*⁴

*We can begin by testing low potency cocaine products -- coca-based chewing gum or lozenges, for example, or products like Mariani's wine and the Coca-Cola of the late 19th century -- which by all accounts were as safe as beer and probably not much worse than coffee. If some people want to distill those products into something more potent, let them.*⁵

*But if there is a lot of PCP use in Washington, then the government comes in and regulates the sale.*⁶

Mr. Nadelmann's view that drugs, including heroin and other highly addictive and dangerous drugs, should be legalized are widely shared by this core group of like-minded individuals. For example, Mr. Arnold Trebach states:

*Under the legalization plan I propose here, addicts . . . would be able to purchase the heroin and needles they need at reasonable prices from a non-medical drugstore.*⁷

³Ethan Nadelmann, *Thinking Seriously About Alternatives to Drug Prohibition*, 121 *Daedalus* 87-132 (1992).

⁴Ethan Nadelmann and Jan Wenner, *Toward a Sane National Drug Policy*, *Rolling Stone* May 5, 1994, 24-26.

⁵*Id.*

⁶Ethan Nadelmann, *How to Legalize*, interview with Emily Yoffe, *Mother Jones*, Feb./Mar. 1990, 18-19.

⁷Arnold Trebach & James Inciardi, *Legalize It? Debating American Drug Policy*, 109-110 (1993).

International financier George Soros, who funds the Lindesmith Center, has advocated: "If it were up to me, I would establish a strictly controlled distributor network through which I would make most drugs, excluding the most dangerous ones like crack, legally available."⁸ William F. Buckley, Jr. has also called for the "legalization of the sale of most drugs, except to minors."⁹

Similarly, when the legalization community explains their theory of harm reduction -- the belief that illegal drug use cannot be controlled and, instead, that government should focus on reducing drug-related harms, such as overdoses -- the underlying goal of legalization is still present. For example, in a 1998 article in *Foreign Affairs*, Mr. Nadelmann expressed that the following were legitimate "harm reduction" policies: allowing doctors to prescribe heroin for addicts; employing drug analysis units at large dance parties, known as raves, to test the quality of drugs; and "decriminalizing" possession and retail sale of cannabis and, in some cases, possession of "hard drugs."¹⁰

Legalization, whether it goes by the name harm reduction or some other trumped up moniker, is still legalization. For those who at heart believe in legalization, harm reduction¹¹ is too often a linguistic ploy to confuse the public, cover their intentions and thereby quell legitimate public inquiry and debate. Changing the name of the plan doesn't constitute a new solution or alter the nature of the problem.

In many instances, these groups not only advocate public policies that promote drug use, they also provide people with information designed to encourage, aid and abet drug use. For example, from the Media Awareness Project (a not-for-profit organization whose self-declared mission is to encourage a re-evaluation of our drug policies) website a child can "link" to a site that states:

*Overthrow the Government!
Grow your own stone! It's easy! It's fun! Everybody's doing it!
Growing marijuana: a fun hobby the whole family can enjoy!*¹²

⁸George Soros, *Soros on Soros*, p. 200 (1995).

⁹William F. Buckley, *The War on Drugs is Lost*, *National Review*, Feb. 12, 1996, 35-48.

¹⁰See Ethan Nadelmann, *Commonsense Drug Policy*, 77 *Foreign Affairs* 111-126 (1998).

¹¹It should, however, be emphasized that not all advocates of harm reduction support drug legalization. Nor, does harm reduction, by itself, require legalization. In fact, aspects of the *National Drug Control Strategy*, such as methadone treatment, properly adopt harm reduction programs as part of a comprehensive, balanced approach to reducing drug use. Nevertheless, the fact remains that many who advocate harm reduction use it as a subterfuge for legalization.

¹²See "www.cannabisculture.com/grow".

The linked website goes on to provide the reader with all the information needed to grow marijuana, including a company located in Vancouver, Canada that will ship seeds or plants.

The Media Awareness Project website also includes links to instructions about how drug users can defeat drug tests.¹³ Similarly, the websites of both the Drug Policy Foundation, a self-proclaimed drug policy reform group, and the Media Awareness Project, both provide links to a site that gives instructions for how to manufacture the drug "ecstasy."¹⁴

Careful examination of the words -- speeches, webpostings, and writings -- and actions of many who advocate policies to "reduce the harm" associated with illegal drugs reveals a more radical intent. In reality, their drug policy reform proposals are far too often a thin veneer for drug legalization.¹⁵

What do drug "legalizers" truly seek? They want drugs made legal -- even though this would dramatically increase drug use rates. They want drugs made widely available, in chewing gums and sodas, over the Internet and at the corner store -- even though this would be tantamount to putting drugs in the hands of children. They want our society to no longer frown on drug use -- even though each year drug use contributes to 50,000 deaths¹⁶ and costs our society \$110 billion

¹³See "www.mapinc.org" ("drug links" 7 and 8 link to the following two websites: "www.hightimes.com/ht/tow/tes/index.html" and "www.cannabisculture.com/usage/dtfaq.shtml").

¹⁴See "www.mapinc.org", which includes as part of its site "www.mapsorg/news.html", which then links to "www.ecstasy.org/links/index.html", which then includes "www.hyperreal.org/~lamont/pharm/faq/faq-mdma-synth.html". This same information is also found on "www.lyceum.org/drugs/synth.../mdma/synthesis/mdma.mda.synthesis".

¹⁵See Richard Cowan, *Building a New NORML*, High Times, Jan. 1993, p. 67. Mr. Cowan has made clear how harm reduction policies fit into the legalization agenda as follows:

Based on our objective of "Legalization by 97" we must begin by demanding: 1 -- immediate access to marijuana for the sick. 2 -- The immediate cessation of all attacks on users, growers and sellers of marijuana. 3 -- An immediate end to lying about marijuana and its users. 4 -- Recognition of the economic and environmental importance of hemp, and studies on how it can be best exploited by American agriculture and industry.

Id.

¹⁶CSR Inc., unpublished research prepared for ONDCP, 1999.

in social costs.¹⁷ And, they want the government to play the role of facilitator, handing out drugs like heroin and LSD.

Let me emphasize, there is nothing wrong with advocating for change in public policy. From civil rights to universal suffrage, much of what makes our nation great has been the result of courageous reform efforts. Our nation benefits from the airing of dissent. However, we all have a responsibility to be honest in debate about our motives. We all have an obligation to be open with the American people about the risks inherent in what we advocate. To date, advocates of legalization have not been so forthcoming.

¹⁷NIDA and NIAAA, *The Economic Costs of Alcohol and Drug Abuse in the United States*, 1992, NIDA/NIH pub. no. 98-4327, Sept. 1998.

II. THE FALLACIES AND REALITIES OF DRUG LEGALIZATION

FALLACY: There is a large movement to legalize drugs in America.

REALITY: THERE IS NO SUCH THING AS A DRUG LEGALIZATION
"MOVEMENT" IN AMERICA.

One recent account placed the number of groups advocating drug policy reform at roughly four-hundred nation-wide, including local chapters of national organizations.¹⁸ By contrast, there are roughly 1,300 local chapters of the American Red Cross; 3,400 units of the American Cancer Society; 9,000 Veterans of Foreign Wars posts; 2,351 local YMCA chapters; 121,948 local Boy Scouts Units; and, 4,300 Community Anti-Drug Coalitions. The "Prevention Through Service Alliance" alone, established by ONDCP, brings together forty-seven national civic, service, fraternal, veterans, and women's organizations, representing one hundred million people and nearly one million local chapters, in a coordinated effort to reduce youth drug use. These organizations are at the forefront of real movements -- to safeguard lives and health, to honor those who served our nation, to end the plague of cancer, to mentor young people, and to protect our youth from drugs. By this standard there is no movement in America to legalize drugs.

There is, however, a carefully-camouflaged, well-funded, tightly-knit core of people whose goal is to legalize drug use in the United States. It is critical to understand that whatever they say to gain respectability in social circles, or to gain credibility in the media and academia, their common goal is to legalize drugs.

FALLACY: Americans increasingly support drug legalization.

REALITY: RIGHTFULLY, THE AMERICAN PUBLIC OPPOSES DRUG
LEGALIZATION.

The American people understand the risks that drug legalization would entail and overwhelmingly reject this ill-considered approach. Youth access to and use of alcohol and cigarettes is bad enough -- American parents clearly don't want children able to use a fake ID at the corner store to buy heroin. We have enough problems with drinking and driving -- families don't want to live in fear that the driver of the eighteen wheeler motoring alongside their minivan is high on marijuana, methamphetamines or LSD. Thousands of our loved ones already die from

¹⁸See Ken Kraysee, *Pot Politics*, Hartford Advocate, May 20, 1999. The Drug Reform Coordination Network's website claims just 6,000 activists in its network. Similarly, the Drug Policy Foundation's website claims "23,000 supporters." And, we believe that there is substantial overlap between groups such as these, as well as other "reform" groups.

drug-related causes -- reasonable people don't want drugs to be accessible over the Internet.

Study after study confirms the concerns of Americans about drugs, and their desire to guard against the risks of these deadly substances. A 1998 poll of voters conducted by the Family Research Council found that eight of ten respondents rejected the legalization of drugs like cocaine and heroin, with seven out of ten in strong opposition. Moreover, when asked if they supported making these drugs legal in the same way that alcohol is, 82 percent said they opposed legalization. Similarly, a 1999 Gallup poll found that 69 percent of Americans oppose the legalization of marijuana.¹⁹ A recent study by the Chicago Council on Foreign Affairs found that the American public consider drug abuse the third biggest problem facing our country today.²⁰

Not only do Americans reject legalization, they also support policies to rid their communities, schools, and workplaces of drugs. For example, a 1995 Gallup poll found that 72 percent of Americans want drug testing in the workplace.²¹ Sixty-seven percent supported random drug testing by employers.²² This same survey found that 73 percent of all American employees support their employers drug-free workplace policies and programs. Another 23 percent of American employees want their employers to go even further and adopt tougher programs. Similarly, a soon-to-be released Gallup poll finds that 85 percent of Americans support greater funding for drug interdiction.²³

One of the best measures of the public's rejection of drugs is the number of Americans -- fifty-million -- who have used drugs during their younger years, but now reject them. Even among individuals who themselves tried drugs, 73 percent believe that parents should forbid children from ever using any drug at any time.²⁴

The American public's opinion about illegal drugs is clear: they want no part of them. Americans don't want their children, friends or family members doing drugs. They don't want drugs in their workplace. They don't want to live in fear that their pilot or bus driver is on drugs.

¹⁹Gallup Organization, *Americans Oppose General Legalization of Marijuana* (1999).

²⁰See John E. Reilly, *Americans and the World: A Survey at the Century's End*, 114 *Foreign Policy* 97, 110 (1999).

²¹Gallup Organization, *What American Employees Think About Drugs* (1995) (prepared for the Institute for a Drug-Free Workplace).

²²*Id.*

²³Gallup, soon to be released poll, prepared for ONDCP (1999).

²⁴Partnership for a Drug Free America, *Parents and Marijuana in the 90s, Partnership Attitude Tracking Study* (1997).

And, they support efforts, ranging from education to treatment to law enforcement, to combat drug use.

FALLACY: Drug legalization will not increase drug use.

REALITY: DRUG LEGALIZATION WOULD SIGNIFICANTLY INCREASE THE HUMAN AND ECONOMIC COSTS ASSOCIATED WITH DRUGS.

Proponents argue that legalization is a cure-all for our nation's drug problem. However, the facts show that legalization is not a panacea but a poison. In reality, legalization would dramatically expand America's drug dependence, significantly increase the social costs of drug abuse, and put countless more innocent lives at risk.

A. "The Dutch Model"

Those who support legalization often hold up the Netherlands as an example that legalization can work. While the Dutch have adopted a "softer" approach to some drugs, they have not legalized them. Under the Dutch system possession and small sales of marijuana have been decriminalized. However, marijuana production and larger scale sales remain criminal. Drugs such as cocaine and heroin remain illegal. Most importantly, while the Dutch have not legalized drugs, the softening of Dutch criminal laws against marijuana has led to a normalization of drug use more broadly. The accompanying change in public attitudes has, arguably, played as critical a role in Dutch drug use patterns as has the shift in the actual law.

If the Dutch experience with drugs is an appropriate model at all, it is because it illustrates the harms that result from increased tolerance of illegal drugs. This conclusion was brought home to all of us from the Office of National Drug Control Policy who traveled to the Netherlands in July of 1998 to gain a better understanding of the Dutch approach.²⁵

When the so-called Dutch "coffee shops," started selling marijuana in small quantities, use of the drug more than doubled between 1984 and 1996 among 18 to 25 year olds.²⁶ According to an article, *Holland's Half-Baked Drug Experiment*, which appears in the current (May/June 1999) edition of *Foreign Affairs*: "In 1997, there was a 25 percent increase in the number of registered cannabis addicts receiving treatment, as compared to a mere 3 percent rise in cases of alcohol

²⁵See Director Barry R. McCaffrey, Memorandum for the President's Drug Policy Council, *ONDCP Trip to Europe (11-18 July 1998)*, September 2, 1998.

²⁶Larry Collins, *Holland's Half-Baked Drug Experiment*, 78 *Foreign Affairs* 82, 88 (May/June 1999); see also Robert Dupont, Eric Voth, *Drug Legalization, Harm Reduction, and Drug Policy*, 123 *Annals of Internal Medicine* 461-465 (1995) (citing a 30 percent increase in the number of Dutch marijuana addicts from 1991 to 1993 alone).

abuse.”²⁷

Moreover, Dutch tolerance of drug use has created a climate that drug manufacturers and traffickers have seized upon to produce and market more addictive and dangerous drugs. For example, Peter Reijnders, Assistant Chief Constable and Chief of the Dutch National Unit on Synthetic Drugs, recently told the 25th European Meeting of Heads of National Drug Services, that: “... [T]he Netherlands is a major country as far as it concerns involvement in the production of illicit synthetic drugs.”²⁸

Dutch drug manufacturers are also producing a new form of marijuana, *Nederwiet*, with THC contents as high as 35 percent -- as much as ten times the THC of the cannabis available just a few years ago. Cannabis seeds can even be ordered over the Internet from an Amsterdam-based dealer.²⁹ The well-respected journal *Foreign Affairs* describes the situation as follows:

... [T]he annual *Nederwiet* harvest is a staggering 100 tons a year, almost all grown illegally. And it does not stay in the Netherlands. Perhaps as much as 65 tons of pot is exported -- equally illegally -- to Holland's neighbors. Holland now rivals Morocco as the principal source of European marijuana. By the Dutch Ministry of Justice's own estimates, the *Nederwiet* industry now employs 20,000 people. The overall commercial value of the industry, including not only the growth and sale of the plant itself but the export of high-potency *Nederwiet* seeds to the rest of Europe and the United States, is 20 billion Dutch guilders, or about \$10 billion -- virtually all of it illegal and almost none of it subject to any form of Dutch taxation. The illegal export of cannabis today brings in far more money than that other traditional Dutch crop, tulips.³⁰

The impact of high potency marijuana on Dutch youth has been severe. In *Foreign Affairs*, Dr. Ernest Bunning of the Ministry of Health, is quoted as saying:

There are young people who abuse soft drugs ... particularly those that have high

²⁷Larry Collins, *Holland's Half-Baked Drug Experiment*, 78 *Foreign Affairs* 82, 88 (May/June 1999).

²⁸See Lecture by Peter Reijnders, llc., Assistant Chief Constable, Chief of the National Unit Synthetic Drugs of the Netherlands, delivered at the 25th European Meeting of Heads of National Drug Services, Edinburgh, UK, May 4-6, 1999.

²⁹See “www.aloha.nl”.

³⁰Larry Collins, *Holland's Half-Baked Drug Experiment*, 78 *Foreign Affairs* 82, 89 (May/June 1999); see also Director Barry R. McCaffrey, Memorandum for the President's Drug Policy Council, *ONDCP Trip to Europe (11-18 July 1998)*, September 2, 1998.

THC. The place that cannabis takes in their lives becomes so dominant they don't have space for other important things in life. They crawl out of bed in the morning, grab a joint, don't work, smoke another joint. They don't know what to do with their lives. I don't want to call it a drug problem because if I do, then we have to get into a discussion that cannabis is dangerous, that sometimes you can't use it without doing damage to your health or your psyche. The moment we say, "There are people who have problems with soft drugs," our critics will jump on us, so it makes it a little bit difficult for us to be objective on this matter.³¹

During this period of tolerance, the Netherlands has also experienced a serious problem with other substances of abuse, in particular heroin and synthetic drugs, which remain illegal. According to a 1998 report from the European Monitoring Centre for Drugs and Drug Addiction, the number of heroin addicts in Holland has almost tripled since the liberalization of drug policies.³² Similarly, the 1998 European Monitoring Centre for Drugs and Drug Addiction's overview report states that drug-related arrests in the Netherlands were up over 40 percent in the last three years, with the main offense being trafficking in so called hard drugs.³³

Increasingly this problem is spilling over to other nations.³⁴ The Netherlands is more and more

³¹*Id.* at p. 87. In this same article, Dr. Wallenberg, head of the Jellinek Clinic, Holland's best known drug clinic, stated: "We have indulged ourselves in a kind of blind optimism in Holland concerning cannabis." *Id.* This apparent inability to critically examine the impacts of quasi-legalized drug policies on drug use trends has substantially aided those in the United States who want to legalize drugs. Absent a full assessment of the increasing drug use trends, proponents of legalization are free to say whatever they like about the success of the model.

³² See European Monitoring Centre for Drugs and Drug Addiction, Study to Obtain Comparable National Estimates of Problem Drug Use, Dec. 1998 (finding 28,000 Dutch heroin addicts in 1997, up from 10,000 in 1979); Larry Collins, *Holland's Half-Baked Drug Experiment*, 78 *Foreign Affairs* 82, 92 (1999) (citing Dutch government funded Trimbo Institute data indicating a tripling of the rate of heroin addiction); see also Robert Dupont, Eric Voth, *Drug Legalization, Harm Reduction, and Drug Policy*, 123 *Annals of Internal Medicine* 461-465 (1995) (citing a 22 percent increase in the number of registered addicts between 1988 and 1993).

³³The European Monitoring Centre for Drugs and Drug Addiction, Annual Report on the State of the Drugs Problem in Europe, 31 (1998). The Netherlands was the only nation among fifteen EU member states listed with trafficking of hard drugs as the main offense driving these increases in drug-related arrests. *Id.*

³⁴See Lecture by Peter Reijnders, Ilc., Assistant Chief Constable, Chief of the National Unit Synthetic Drugs of the Netherlands, delivered at the 25th European Meeting of Heads of National Drug Services, Edinburgh, UK, May 4-6, 1999 (noting that 26 different countries worldwide have reported seizures of MDMA originating in the Netherlands, including 124 cases

seen as Europe's synthetic drug production center by law enforcement agencies. It is reported that British Customs has determined that virtually all the synthetic drugs seized in the United Kingdom last year were manufactured in the Netherlands or Belgium.³⁵ Similar reports suggest that 98 percent of the amphetamines seized in France in 1997 came from Holland, as did 73.6 percent of the ecstasy tablets.³⁶ Synthetic drugs manufactured in the Netherlands are also now increasingly turning up in the United States.³⁷

These impacts are not lost upon the Dutch people who increasingly support a more balanced approach to fighting drug use. A 1995 poll by Telepanel, a polling organization associated with the University of Amsterdam found that nearly three-quarters of the Dutch people want tougher measures against those who deal in *and* use drugs.³⁸ Despite the normalization of marijuana in the Netherlands over half the Dutch people believe "soft drugs" should be criminalized.³⁹ By way of comparison, these numbers are far higher than the support for alternative drug policies in the United States.⁴⁰

Proponents of legalization argue that the Dutch experience provides a model for a "softer approach" to fighting drug use. Upon close examination the pitfalls of the Dutch experience offer more than ample evidence to dissuade the United States from adopting the drug policies of the Netherlands.⁴¹ Instead the Dutch example clearly argues in favor of continuing the balanced

involving more than 500 grams).

³⁵Larry Collins, *Holland's Half-Baked Drug Experiment*, 78 Foreign Affairs 82, 84 (1999).

³⁶*Id.*

³⁷*Id.* at 97.

³⁸Hassela Nordic Network, Press Release, Nov. 9, 1995.

³⁹Hassela Nordic Network, Press Release, June 14, 1995 (poll by the newspaper *Algemeen Dagblad*); Hassela Nordic Network, Press Release, Nov. 9, 1995 (poll by Erasmus University, Rotterdam, finding 61 percent of Dutch think all drugs should be prohibited).

⁴⁰See, e.g., Gallup Organization, *Americans Oppose General Legalization of Marijuana* (1999).

⁴¹The experiences of other nations that have flirted with legalization-like schemes also provide evidence that legalization is not a viable policy option. For example, in 1964, Great Britain began providing medical prescriptions for heroin to addicts. The policy was discontinued because it caused a 100 percent increase in the numbers of addicts and contributed to a significant increase in crime. See Drug Enforcement Administration, *Drug Legalization: Myths*

U.S. approach, which is producing results.

and Misconceptions, 17 (1994). Similarly, during ONDCP's 1998 trip to Sweden, Swedish officials described how that nation had tried and rejected a more liberalized approach to drug control because use rates and attendant harms had increased significantly with the liberalization.

B. The American Experience

American experiences with drug legalization portend similar risks to those experienced in Holland. During the 1970s, our nation engaged in a serious debate over the shape of our drug control policies. (For example, within the context of this debate, between 1973 and 1979, eleven states “decriminalized” marijuana). During this timeframe, the number of Americans supporting marijuana legalization hit a modern-day high.⁴² While it is difficult to show causal links, it is clear that during this same period, from 1972 to 1979, marijuana use rose from 14 percent to 31 percent among adolescents, 48 percent to 68 percent among young adults, and 7 percent to 20 percent among adults over twenty-six.⁴³ This period marked one of the largest drug use escalations in American history.

A similar dynamic played out nationally in the late 1800’s and early 1900’s. Until the 1890s, today’s controlled substances -- such as marijuana, opium, and cocaine -- were almost completely unregulated.⁴⁴ It was not until the last decades of the 1800s that several states passed narcotics control laws.⁴⁵ Federal regulation of narcotics did not come into play until the Harrison Act of 1914.

Prior to the enactment of these laws, narcotics were legal and widely available across the United States. In fact, narcotics use and its impacts were commonplace in American society. Cocaine was found not only in early Coca-Cola (until 1903) but also in wine, cigarettes, liqueur-like alcohols, hypodermic needles, ointments, and sprays. Cocaine was falsely marketed as a cure for hay fever, sinusitis and even opium and alcohol abuse. Opium abuse was also widespread. One year before Bayer introduced aspirin to the market, the company also began marketing heroin as a “nonaddictive,” no prescription necessary, over-the-counter cure-all.

During this period, drug use and addiction increased sharply. While there are no comprehensive studies of drug abuse for this period that are on par with our current *National Household Survey on Drug Abuse* and *Monitoring the Future* studies, we can, for example, extrapolate increases in

⁴²See Bureau of Justice Statistics, *Sourcebook of Criminal Justice Statistics* 1997, 150-151 (1997). In 1973, 18 percent of the American people supported legalization of marijuana. In 1997, that number grew to 28 percent. By 1978, that number reached 30 percent, the highest it has reached from the 1970’s to date.

⁴³See ADAMHA, PHS, DHHS, *National Household Survey on Drug Abuse: Main Findings 1985* (1988).

⁴⁴See David Musto, *The American Disease*, 10 (1972).

⁴⁵*Id.* at p. 10, 91-95. Pennsylvania passed the first state-level anti-morphine law as early as 1860. *Id.* at p. 91. Ohio followed suit with an anti-opium smoking law in 1897. *Id.*

opium use from opium imports, which were tracked.⁴⁶ Yale University's Dr. David Musto, one of the leading experts on the patterns of drug use in the United States, writes: "The numbers of those overusing opiates must have increased during the nineteenth century as the per capita importation of crude opium increased from less than 12 grains annually in the 1840s to more than 52 grains in the 1890s."⁴⁷ Only in the 1890s when societal concerns over and disapproval of drug use began to become widespread and triggered legal responses did these rates level off.⁴⁸ Until this change in attitudes began to denormalize drug use, the United States experienced over a 400 percent increase in opium use alone. This jump is even more staggering if one considers that during this period other serious drugs, such as cocaine, were also widely available in everyday products.

Moreover, while we do not believe that the period of prohibition on alcohol is directly analogous to current efforts against drugs,⁴⁹ our experiences with alcohol prohibition also raise parallel concerns. While prohibition was not without its flaws, during this period alcohol usage fell to between 30 to 50 percent of its pre-prohibition levels.⁵⁰ From 1916 to 1919 (just prior to prohibition went into effect in 1920), U.S. alcohol consumption averaged 1.96 gallons per person per year.⁵¹ During prohibition, alcohol use fell to a low of .90 gallons per person per year.⁵² In the decade that followed prohibition's repeal, alcohol use increased to a per capita annual

⁴⁶During this period almost all U.S. opium was imported for domestic use with little or no transshipment. Thus, for this timeframe rates of imports are the best indicator for rates of domestic use. *Id.* at p. 252, note 5.

⁴⁷*Id.* at p. 5. Domestic demand for opium began to increase in the 1840s and continued to grow until roughly the 1890s. At its peak in the 1890s domestic consumption of crude opium leveled off at a high of 500,000 pounds each year. At the same time, morphine and morphine salts consumption reached 20,000 ounces annually. *Id.* at p. 252, note 5.

⁴⁸*Id.* at p. 252, note 5, and accompanying text.

⁴⁹Most importantly, prohibition sought to stop a societal behavior that was socially accepted and widespread. In contrast, our current drug policies are backed by overwhelming societal disapproval of drugs. See Robert Dupont, Eric Voth, *Drug Legalization, Harm Reduction, and Drug Policy*, 123 *Annals of Internal Medicine* 461-465 (1995).

⁵⁰Paul Aaron and David Musto, *Temperance and Prohibition in America: A Historical Overview*, in *Beyond the Shadow of Prohibition*, 164-165 (Mark H. Moore & Dean P. Gerstein eds., 1981).

⁵¹Arnold Trebach & James Inciardi, *Legalize It? Debating American Drug Policy*, 109-110 (1993).

⁵²*Id.*

average of 1.54 gallons and has since steadily risen to 2.43 gallons in 1989.⁵³ Prohibition also substantially reduced the rates of alcohol-related illnesses.⁵⁴

The United States has tried drug legalization and rejected it several times now because of the suffering it brings. The philosopher Santayana was right in his admonition that “those who cannot remember the past are condemned to repeat it.” Let us not now be so foolish as to once again consider this well worn, dead-end path.

C. The Impact on Youth

Most importantly the legalization of drugs in the United States would lead to a disproportionate increase in drug use among young people. In 1975, the Alaskan Supreme Court invalidated certain sections of the state’s criminal code pertaining to the possession of marijuana. Based on this finding, from 1975 to 1991, possession of up to four ounces of the drug by an adult who was lawfully in the state of Alaska became legal.⁵⁵ Even though marijuana remained illegal for children, marijuana use rates among Alaskan youth increased significantly.⁵⁶ In response, concerned Alaskans, in particular the National Federation of Parents for Drug-Free Youth, sponsored an anti-drug referendum that was approved by the voters in 1990, once again rendering marijuana illegal.

In addition to the impact of expanded availability, legalization would have a devastating effect on how our children see drug use. Youth drug use is driven by attitudes. When young people perceive drugs as risky and socially unacceptable youth drug use drops. Conversely, when children perceive less risk and greater acceptability in using drugs, their use increases. If nothing else, legalization would send a strong message that taking drugs is a safe and socially accepted behavior that is to be tolerated among our peers, loved ones and children. Such a normalization would play a major role in softening youth attitudes and, ultimately, increasing drug use.

⁵³*Id.*

⁵⁴See Mark H. Moore, *Actually, Prohibition Was a Success*, New York Times, A21, Oct. 16, 1989. During prohibition, cirrhosis death rates for men went from 29.5 per 100,000 in 1911, to 10.7 per 100,000 in 1929. Admissions to state mental hospitals for alcohol psychosis also fell from 10.1 per 100,000 in 1919 to 4.7 per 100,000 in 1928. *Id.*; see also John Noble, *et al.*, *Cirrhosis Hospitalization and Mortality Trends 1970-87*, 108 Public Health Reports 192 (1993).

⁵⁵See *Rain v. Stark*, 537 P.2d 494 (AK 1975). The court’s holding did not effect the statutory provisions dealing with the purchase, sale or manufacture of marijuana, which remained illegal during this period.

⁵⁶Information provided by Drug Watch International (citing Bernard Segal, Center for Alcohol and Addiction Studies University of Alaska, *Drug Taking Behavior Among Alaskan Youth -- 1988*, Nov. 1988).

The significant increases in youth drug use that would accompany legalization are particularly troubling because their effects would be felt over the course of a generation or longer. Without help, addictions last a lifetime. Every additional young person we allow to become addicted to drugs will impose tremendous human and fiscal burdens on our society. Legalization would be a usurious debt upon our society's future -- the costs of such an approach would mount exponentially with each new addict, and over each new day.

D. The Impact of Drug Prices

If drugs were legalized, we can also expect that the attendant drop in drug prices to cause drug use rates to grow as drugs become increasingly affordable to buy.⁵⁷ Currently a gram of cocaine sells for between \$150 and \$200 on U.S. streets.⁵⁸ The cost of cocaine production is as low as \$3 per gram.⁵⁹ In order to justify legalization, the market cost for legalized cocaine would have to be set so low as to make the black market, or bootleg cocaine, economically unappealing.⁶⁰ Assume, for argument sake, that the market price was set at \$10 per gram, a three hundred percent plus markup over cost, each of the fifty hits of cocaine in that gram could retail for as little as ten cents.

With the cost of "getting high" so as low as a dime (ten cents) -- about the cost of a cigarette -- the price of admission to drug use would be no obstacle to anyone even considering it.⁶¹ However, each of these "dime" users risks a life-long drug dependence problem that will cost them, their families, and our society tens of thousands of dollars.

⁵⁷See Grossman *et al.*, *Rational Addiction and the Effect of Price on Consumption*, in *Searching for Alternatives*, at p. 77 (Melvyn B. Kraus & Edward P. Lear, eds. 1991) (with respect to cigarettes a 10 percent drop in price yields a 7 to 8 percent increase in demand).

⁵⁸ABT Associates, *The Price of Illicit Drugs: 1981 Through Second Quarter of 1998*, prepared for ONDCP (Feb. 1999).

⁵⁹Moreover, the cost of production of legalized cocaine would shrink below today's levels. For example, the shipment of legal cocaine without the need to conceal, the movement of profits without the need to launder, and the ability to manufacture without and market without losses to law enforcement, would all provide significant economies.

⁶⁰See George Soros, *Soros on Soros*, 200 (1995) (recognizing the need to set prices of legalized drugs low enough to undercut a black market).

⁶¹The impact of pricing on youth substance use is well established with respect to alcohol and taxes. Moreover, one study has found that increases in alcohol prices not only reduces youth alcohol consumption, but also marijuana use. See Rosalie Liccardo Pacula, *Does Increasing the Beer Tax Reduce Marijuana Consumption?*, 17 J. Health Economics 557-585 (1998).

In addition to the impact on youth, we would also expect to see falling drug prices drive increasing drug use among the less affluent. Among these individuals the price of drug use -- even at today's levels -- remains a barrier to entry into use and addiction. The impact of growing use within these populations could be severe. Many of these communities are already suffering the harms of drug use -- children who see no other future turning to drugs as an escape, drug dealers driving what remains of legitimate business out of their communities, and families being shattered by a loved one hooked on drugs. Increased drug use would set back years of individual, local, state and federal efforts to sweep these areas clean of drugs and build new opportunities.

FALLACY: Drug legalization would reduce the harm of drug use on our society.

REALITY: DRUG LEGALIZATION WOULD COST BILLIONS OF DOLLARS AND RISK MILLIONS OF ADDITIONAL INNOCENT LIVES.

By increasing the rates of drug abuse, legalization would exact a tremendous cost on our society. If drugs were legalized, the United States would see significant increases in the number of drug users, the number of drug addicts, and the number of people dying from drug-related causes.

While many of these costs would fall first and foremost on the user, countless other people would also suffer if drugs were legalized. Contrary to what libertarians and legalizers would have us believe, drug use is not a victimless crime.

A. Increases in Child Abuse and Neglect

Innocent children suffer the most from drug abuse. In *No Safe Havens*, experts from Columbia University's Center for Addiction and Substance Abuse found that substance abuse (including drugs and alcohol) exacerbates seven of every ten child abuse or neglect cases.⁶² In the last ten years, driven by substance abuse, the number of abused and neglected children has more than doubled, up from 1.4 million in 1986 to three million in 1997.⁶³ In 1994, *the American Journal of Public Health* reported that children whose parents abuse drugs or alcohol are four times more likely to be neglected and/or abused than children with parents who were not drug abusing.⁶⁴

⁶²Jeanne Reid, et al., *No Safe Haven: Children of Substance Abusing Parents* (1990) (published by the National Center on Addiction and Substance Abuse at Columbia University).

⁶³*Id.*

⁶⁴Chaffin M. Kellechek, Fischer E. Hollenberg, *Alcohol and Drug Disorders Among Physically Abusive and Neglectful Parents in a Community-Based Sample*, 84 Am. J. Public Health 1586-90 (1994).

If drugs were made legal, among the growing ranks of the addicted will be scores of people with children. Given the clear linkage between rates of addiction and child abuse and neglect, more drug use will cause tens of thousands of additional children to suffer from abuse and neglect as parents turn away from their children to chase their habit.

B. Increases in Drugged Driving Accidents

Over the last ten years, Americans have grown increasingly aware of the death toll related to drinking and driving. While we focus less on the risks of drugged-driving, the fact is that if the driver on the road next to you is drugged, you and whoever is riding with you are at risk. A National Transportation Safety Board study of 182 fatal truck accidents revealed that 12.5 percent of the drivers had used marijuana, in comparison to 12.5 percent who used alcohol, 8.5 percent who used cocaine and 7.9 percent who used stimulants.⁶⁵ Illegal drugs (marijuana, cocaine, and stimulants combined) were present in more accidents than alcohol -- even though alcohol is legal and far more available. "A study of 440 drivers, ages 15 to 34 years old, who were killed in California during a two-year period detected alcohol and marijuana in one-third of victims. More than one-half consumed a drug or drugs other than alcohol."⁶⁶

Historically, we believe that impaired drivers drive more recklessly. A 1995 roadside study conducted in Memphis, Tennessee of reckless drivers not believed to be impaired by alcohol, found that 45 percent tested positive for marijuana.⁶⁷

Most disturbingly, drugged driving often appears among the most inexperienced drivers, namely young people. The *1996 National Household Survey on Drug Abuse* found that 13 percent of young people aged sixteen to twenty drove a car less than two hours after drug use at least once during the past year.⁶⁸ These young drivers are generally unaware of the dangers they present to

⁶⁵National Transportation Safety Board Report, Washington, D.C., February 5, 1990.

⁶⁶NHTSA, *The Highway Safety Deskbook*, Part IV (1996).

⁶⁷Brookoff, D. et al., *Testing Reckless Drivers for Cocaine and Marijuana*, 320 New Eng. J. Med. 762-768 (1994).

⁶⁸Office of Applied Statistics, *Driving After Drugs or Alcohol Use: Findings From the 1996 National Household Survey on Drug Abuse* (1998) (published by NHTSA, DOT, SAMSHA and HHS). Findings with respect to youth drinking and driving also suggest that if drugs were made legal, drugged driving would be most problematic among young people. See, e.g., National Highway Traffic Safety Administration, *Alcohol Traffic Safety Facts 1997, 1997* (the highest intoxication rates in fatal crashes in 1997 were recorded for drivers 21-24 years old).

themselves and others. Among 16 to 20 year olds who drove after marijuana use, 57 percent said they did so because they were not "high enough to cause a crash."⁶⁹

When a person using drugs takes the wheel, his drug use is likely to have human costs. Not only is the drugged driver at risk, but all those around him are as well. On January 29, 1999, a car with five young girls -- high school juniors in a middle class suburb of Philadelphia -- crashed into a tree, killing the driver and the other occupants.⁷⁰ The medical examiner's report concluded that the driver lost control of the car not because of speed or inexperience but because she was impaired from "huffing" -- inhaling a chemical solvent -- to get high. Three of the passengers were also found to have used the drug. Five more young people, all with bright futures, are dead because of drug use behind the wheel.

If drugs were legalized the rate of drugged driving would increase. Added to the countless tragedies caused by drinking and driving would be scores of deaths and injuries from people taking legalized drugs and driving while impaired.

According to the National Highway Traffic Safety Administration (NHTSA), there were 16,189 alcohol-related traffic fatalities in 1997 (38.6 percent of the total traffic fatalities for the year).⁷¹ NHTSA also reports that in 1997, more than 327,000 people were injured in auto crashes where police reported that alcohol was present.⁷² These tragic statistics make abundantly clear the risks we would face if other drugs, such as heroin, marijuana and LSD, were made legal and widely available.

C. Increases in Workplace Accidents, Decreasing Productivity

Just as drug impairment behind the wheel puts others at risk, so too does impairment on the job. Since over 60 percent of drug users in the United States are employed,⁷³ it is not surprising that workplace drug use is a significant problem. According to a 1995 Gallup survey, 35 percent of

⁶⁹Office of Applied Statistics, *Driving After Drugs or Alcohol Use: Findings From the 1996 National Household Survey on Drug Abuse* (1998) (published by NHTSA, DOT, SAMSHA and HHS).

⁷⁰*See, e.g.,* CNN The World Today, *Deaths of Five Schoolgirls in Philadelphia Car Crash Raises Awareness of Chemical Inhalants*, Mar. 2, 1999, 8:24 pm EST (LEXIS/NEXIS).

⁷¹National Highway Traffic Safety Administration, *Alcohol Traffic Safety Facts 1997*, 1997.

⁷²*Id.*

⁷³Office of Applied Studies, SAMSHA, *National Household Survey on Drug Abuse: Main Findings 1997* (1998).

American employees report having seen drug use on-the-job by co-workers.⁷⁴ One-in-ten report having been offered drugs while at work.⁷⁵ Drug use in the workplace diminishes productivity and increases costs.⁷⁶ Drug using employees are more likely to have taken an unexcused absence in the last month, and are more likely to change or leave a job.⁷⁷ The National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism estimated that the cost to our nation's productivity from illegal drug use was \$69.4 billion in 1992.⁷⁸ Increasing rates of drug use burden our economy as a whole. They also place businesses, in particular small businesses, at risk. In the end, it is the American consumer who ultimately pays these costs.

When drugs are mixed with the heavy machinery of industry, the results can be devastating. In 1987, a Conrail freight train operated by an engineer who had been smoking marijuana struck an Amtrak passenger train, killing sixteen people and injuring more than one-hundred.⁷⁹ Last July, a passenger train and a truck carrying steel coils collided.⁸⁰ The driver of the truck, who was cited by police for more than a dozen violations relating to the crash, tested positive for marijuana immediately following the accident. The collision dislodged one of the twenty-ton coils, causing it to roll through the train's first passenger compartment, killing three and injuring

⁷⁴Gallup Organization, *What American Employees Think About Drugs* (1995) (prepared for the Institute for a Drug-Free Workplace).

⁷⁵*Id.*

⁷⁶*See, e.g.,* Robert Dupont, *Never Trust Anyone Under 40: What Employers Should Know About Drug Testing* 48 Policy Review pp. 52-57 (1989) (drug using workers are 3 to 4 times as likely to have an on-the-job accident, 2 to 3 times as likely to file a medical claim, and 25 to 35 percent less productive).

⁷⁷ONDCP, *The 1999 National Drug Control Strategy*, 17 (1999).

⁷⁸The National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism, *The Economic Costs of Alcohol and Drug Abuse in the United States, 1992*, 5-1 (1998).

⁷⁹*See, e.g.,* CNN NEWS, *A Historical Perspective on Amtrak Accidents*, Sept. 22, 1993; Lori Sharn, *Will Tests Keep Booze Out of Cabs, Cockpits*, USA Today, Jan. 14, 1992, 1A; Rep. Bob Whittaker, *The Drugs and Alcohol Crisis: Congress Must Pass Legislation Requiring Workers to Take Drug and Alcohol Tests Before Assuming Life Threatening Responsibilities*, Roll Call, July 23, 1990, Briefing No. 17.

⁸⁰*See, e.g.,* Jon Hilkevich, *Police Say Test Shows Drug Use By Trucker in Train Crash*, Chicago Tribune, June 25, 1998, 1; *Marijuana Found in Trucker Involved in Fatal Train Wreck*, New York Times, June 25, 1998, A16.

others.⁸¹

Highly publicized disasters like these capture the public's attention. However, the harms of drug abuse build incrementally on job sites all across the nation, every day. Utah Power & Light employees who tested positive on pre-employment drug tests were five times more likely to be involved in a workplace accident than those who tested negative.⁸² The 1995 Gallup survey similarly found that 42 percent of American employees believe that drug use greatly affects workplace safety.⁸³ Even these numbers are likely to underestimate the harms caused by drugs on-the-job; for a variety of reasons drug-related on-the-job injuries are likely under-reported.

One way to factor the risks presented by on-the-job drug use is to extrapolate from the rate at which drug-free workplace programs can reduce job-related accidents. For example, the Boeing corporation's drug-free workplace program has saved over \$2 million in employee medical claims.⁸⁴ At Southern Pacific railroad, the injury rate dropped 71 percent with the development of a drug-free workplace assistance program.⁸⁵ One of the major auto manufacturers has reported 82 percent decline in job-related accidents since implementing an employee substance abuse assistance program. Similarly, an Ohio study found that substance abuse treatment programs significantly reduced on-the-job injuries.⁸⁶ If job-related drug assistance programs can prevent such high rates of accidents, it follows that drugs cause large numbers of injuries among America's employees.

If drugs were made legal, use -- including on-the-job drug use -- will increase. Growing numbers of drug users operating heavy equipment, driving tractor-trailers, and operating buses, would inevitably lead to greater numbers of workplace injuries. While the impaired drug user is most at risk from their own actions, countless innocent people -- co-workers and ordinary citizens --

⁸¹See *supra* n. 80.

⁸²See Testimony of Mark A. DiBernardo, Executive Director, Institute for a Drug-Free Workplace, Before the House Committee on Government Reform and Oversight, Subcommittee on National Security, International Affairs and Criminal Justice, on Employer Drug-Testing and Drug Abuse Prevention, June 27, 1996.

⁸³The Gallup Organization, *What American Employees Think About Drugs* (1995) (prepared for the Institute for a Drug-Free Workplace).

⁸⁴Dan Rhodes, *Drugs in the Workplace*, 67 *Occupational Health & Safety* 136-138 (1998).

⁸⁵*Id.*

⁸⁶*Id.* (The Ohio study found that substance abuse treatment programs could reduce on-the-job injuries by as much as 97%).

would also face added dangers. Additionally, apart from the human costs, significantly increased numbers of on-the-job drug-related accidents would cost the American economy countless millions -- ranging from rising insurance costs, to personal injury settlements, to losses through decreased productivity.

FALLACY: Drugs are harmful because they are illegal.

REALITY: DRUGS ARE HARMFUL NOT BECAUSE THEY ARE ILLEGAL; THEY ARE ILLEGAL BECAUSE THEY ARE HARMFUL.

Critics argue that the harm to our society from drugs, such as the costs of crime, could be reduced if drugs were legalized. The logic is flawed. By increasing the availability of drugs, legalization would dramatically increase the harm to innocent people. With more drugs and drug use in our society, there would be more drug-related child abuse, more drugged driving fatalities, and more drug-related workplace accidents. None of these harms are caused by law or law enforcement but by illegal drugs.

Even with respect to the crime-related impact of drugs, drug-related crimes are driven far more by addiction than by the illegality of drugs. Law enforcement doesn't cause people to steal to support their habits; they steal because they need money to fuel an addiction -- a drug habit that often precludes them from earning an honest living. Even if drugs were legal, people would still steal and prostitute themselves to pay for addictive drugs and support their addicted lifestyles. Dealers don't deal to children because the law makes it illegal; dealers deal to kids to build their market by hooking them on a life-long habit at an early age, when drugs can be marketed as cool and appealing to young people who have not matured enough to consider the real risks. Make no mistake: legalizing drugs won't stop pushers from selling heroin and other drugs to kids. Legalization will, however, increase drug availability and normalize drug-taking behavior, which will increase the rates of youth drug abuse.

For example, although the Dutch have adopted a more tolerant approach to illegal drugs, crime is in many cases increasing rapidly in Holland. The most recent international police data (1995) shows that Dutch per capita rates for breaking and entering, a crime closely associated with drug abuse, are three times the rate of those in Switzerland and the United States, four times the French rate, and 50 percent greater than the German rate.⁸⁷ "A 1997 report on hard-drug use in the Netherlands by the government-financed Trimbos Institute acknowledged that 'drug use is considered the primary motivation behind crimes against property' -- 23 years after the Dutch

⁸⁷See Interpol, *International Crime Statistics* (1995); see also Director Barry R. McCaffrey, Memorandum for the President's Drug Policy Council, *ONDCP Trip to Europe (11-18 July 1998)*, September 2, 1998.

[drug] policy was supposed to put a brake on that."⁸⁸ Moreover, *Foreign Affairs* recently noted that in areas of Holland where youth cannabis smokers are most prevalent, such as Amsterdam, Utrecht and Rotterdam, the rates of juvenile crime have "witnessed skyrocketing growth" over the last three to four years.⁸⁹ Statistics from the Dutch Central Bureau of Statistics indicate that between 1978 and 1992, there was a gradual, steady increase in violence of more than 160 percent.⁹⁰

In contrast, crime rates in the United States are rapidly dropping. For example, the rate of drug-related murders in the United States has hit a ten-year low.⁹¹ In 1989, there were 1,402 drug-related murders. By 1997 that number fell to 786. In 1995, there were 581,000 robberies in the United States. By 1997, that number fell to roughly 498,000.⁹²

America's criminal justice system is not the root cause of drug-related crime. It is the producers, traffickers, pushers, gangs and enforcers who are to blame, as are all the people who use drugs and never think about the web of criminality and suffering their drug money supports.

FALLACY: We are fighting a war on drugs.

REALITY: OUR BALANCED EFFORTS AGAINST DRUGS ARE ANALOGOUS TO THE FIGHT AGAINST CANCER.

Wars have defined end states -- victory over an enemy. Our efforts against drugs have no such neatly defined end; with each generation the struggle to prevent drug use begins anew. Addicted Americans -- parents, siblings, and children -- are not the enemy, they require treatment. Wars are waged with weapons and soldiers; prevention and treatment are our primary tools against drugs. Consequently, our efforts to reduce drug use are analogous to the fight against cancer.

Nevertheless, an effective counter-drug strategy must focus on both supply and demand reduction. Supply-side efforts (law enforcement and interdiction) are necessary because, as basic economic rules dictate, unabated supply will ultimately create its own demand. However, those

⁸⁸Larry Collins, *Holland's Half-Baked Drug Experiment*, 78 *Foreign Affairs* 82, 92 (1999).

⁸⁹*Id.* at 88.

⁹⁰P. Van Kalleveen, *Violent Crimes in Central Bureau of Statistics, Justitie Verkenningen* (1), 29-47 (1994).

⁹¹Federal Bureau of Investigation, *Uniform Crime Report for the United States* (1997).

⁹²*Id.*

of us who have experienced combat know that such supply-side efforts are a far cry from "war." In fact, the use of civilian authorities to protect against drugs is no more war-like than the same role these same police officers play in combating robberies, car thefts, or domestic violence. It is sheer folly to suggest that when a police officer patrols a neighborhood to stop these other crimes he is doing a community service, however when he finds drugs, his efforts somehow become part of a conjured up "drug war."

FALLACY: Our current approach to drugs is not making a difference.

REALITY: WE ARE MAKING STRONG, STEADY PROGRESS IN REDUCING DRUG USE AND PREVENTING YOUNG PEOPLE FROM TURNING TO DRUGS.

Rather than trade rhetoric, we should focus on results:

- Over the last twenty years we have cut drug use (past month) in the United States by half and reduced cocaine use by 75 percent (past month).⁹³
- Over the last two years, youth drug use rates have leveled off and in many cases have begun to fall. This shift marks a sharp departure from the prior six years, which saw steady increases in youth drug use. Most importantly, we have begun to see a sharpening of youth attitudes against drugs -- youth increasingly see drugs as risky and unacceptable.⁹⁴
- The number of drug-related murders has now hit a ten-year low. In 1989, there were 1402 drug-related murders; by 1997 that number had fallen to 786.⁹⁵
- Spending on illegal drugs has dropped 37 percent from 1988 to 1995, an annual savings of \$34.1 billion.⁹⁶

Such results against any other societal ill would be called a huge success. Let me thank the Committee and the Congress as a whole for your bipartisan support of our counter-drug programs. Without your strong support results like these would not have been possible.

⁹³Office of Applied Statistics, SAMSHA, *National Household Survey on Drug Abuse: Main Findings 1997* (1998).

⁹⁴*Id.*

⁹⁵Federal Bureau of Investigation, *Uniform Crime Report for the United States* (1997).

⁹⁶ONDCP, *What America's Users Spend on Illegal Drugs, 1988-1995*, 1 (1997).

III. THE SOLUTION TO AMERICA'S DRUG PROBLEM IS THE BALANCED APPROACH EMBODIED IN OUR NATIONAL DRUG CONTROL STRATEGY

There is no simple solution to America's drug problem. In order to effectively address this problem we must attack both the supply and demand for drugs. Pursuing one of these goals at the expense of the other will only unbalance our efforts and reduce the likelihood of success.⁹⁷

The *National Drug Control Strategy* establishes a multi-year framework to reduce illegal drug use and availability by 50 percent within ten years. If this target is achieved, less than 3 percent of the household population aged twelve and over would use illegal drugs -- the lowest recorded drug-use rate in modern American history. Drug-related health, economic, social, and criminal costs would be reduced commensurately. To achieve this target, the *Strategy* focuses on prevention, treatment, research, law enforcement, protection of our borders, and international cooperation.

The *National Drug Control Strategy* is guided by five goals that cover the three broad aspects of drug control -- demand reduction, supply reduction, and the adverse consequences of drug abuse and trafficking. Reducing the demand for illegal drugs is the centerpiece of our *Strategy*, but supply reduction and consequence management are also critical components of a well-balanced strategic approach to drug control. The five goals reflect the need for prevention and education to protect all Americans (especially children) from the perils of drugs, treatment to help the chemically dependent, law enforcement to bring traffickers and other drug offenders to justice, interdiction to reduce the flow of drugs into our nation, and international cooperation to confront drug cultivation, production, trafficking, and use.

⁹⁷*Accord*, National Research Council, Assessment of Two Cost-Effectiveness Studies on Cocaine Control Policy (1999) (finding that two separate studies commonly used to justify spending on particular anti-drug efforts at the expense of other anti-drug efforts were both flawed). The National Research Council study commissioned by ONDCP, reviewed the earlier findings of a study by the Institute for Defense Analysis (IDA) on the cost effectiveness of interdiction efforts. The IDA Study has been used by some to advocate dramatically expanded spending on interdiction at the expense of a more balanced approach. Recently, the National Research Council found that the research foundation of the IDA study is inadequate to serve as the basis for sound public policy. The Council also assessed the RAND study, *Controlling Cocaine: Supply Versus Demand Programs*, which concluded that marginal dollars should be spent on treatment rather than supply control. The NRC concluded that while the RAND study serves as an important point of departure for the development of richer models of the market for cocaine, the findings do not constitute a persuasive basis for the formulation of cocaine control policy.

1. Goals of the 1999 Strategy

- Goal 1:** Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.
- Goal 2:** Increase the safety of America's citizens by substantially reducing drug-related crime and violence.
- Goal 3:** Reduce health and social costs to the public of illegal drug use.
- Goal 4:** Shield America's air, land, and sea frontiers from the drug threat.
- Goal 5:** Break foreign and domestic drug sources of supply.

2. Overview of the Strategy

The *National Drug Control Strategy* takes a long-term, holistic view of the nation's drug problem. The document maintains that no single solution can suffice to deal with the multifaceted issue, that several solutions must be applied simultaneously, and that focusing on outcomes -- measured in declining drug use and a lessening of attendant social consequences -- can achieve our goals. Our Strategy focuses on those approaches that we know work in reducing drug use.

3. Educating Young People

Our primary focus is on preventing youth drug use. Studies show that attitudes about drugs drive youth drug use rates. Preventing drug use before it starts is more effective and cost efficient than trying to break a person free from an already established addiction. By reaching young people before they try drugs, we can help them reject these deadly substances and go on to full, safe, and productive lives.

Our commitment to prevention is backed by significant resources. With the support of Congress in passing our FY2000 counter-drug budget, we will increase federal drug prevention funds by 55 percent since FY1996. Your continued support for our drug prevention efforts is critical to protecting our nation's children and will build upon our common efforts to date.

For example, with the bipartisan support of Congress, we have launched the National Youth Anti-Drug Media Campaign, a five-year \$2 billion public-private partnership. The Media Campaign is using the full power of modern media -- from television to the Internet to sports marketing -- to educate children, parents, and other adult influencers about the dangers of drugs.

Already, the Campaign is producing results:

- Phase I of the Campaign achieved our objective of increasing awareness. Our evaluation shows that youth and teens demonstrated significant increases in ad recall in the target versus the comparison sites -- youth increases ranged from 11 to 26 percent, teens ranged from 13 to 27 percent. Parents in target sites had an 11 percent gain in awareness of the risks of drugs and said that the Campaign provided them with new information about drugs (a 7 percent increase).
- **The Campaign's initial target for "reach and frequency" was to reach 90 percent of our overall teen target audience (young people ages nine to eighteen) with anti-drug messages four times per week.**
- **The Campaign is already reaching 95 percent of our youth target audience 6.8 times per week.**
- **With respect to our reach, we are reaching nearly every single American child on a regular basis with anti-drug information. With respect to frequency, we are putting this information in front of them at a rate of roughly twice our goal.**
- **We are buying advertising in 2250 media outlets nationwide (newspaper, TV, radio, magazines, billboards, movie theaters, and others). By any standard, the Campaign is the strongest multi-cultural communications effort ever launched by the federal government and rivals that of most corporate efforts.**
- **Among African American youth within the target age audience, we are doing even better -- reaching 95 percent of the young people 7.8 times per week.**
- **Within the Hispanic youth target group, we are reaching 94 percent of our audience with messages in Spanish 4.8 times per week -- not to mention the substantial impact of messages in English on bilingual young people.**
- **The Campaign delivers \$33 million worth of anti-drug messages per year to ethnic young people and their adult influencers (e.g., parents, grandparents, coaches, teachers, civic leaders, the faith community, and others).**
- **We are now developing campaign materials in ten additional languages.**
- **We are the largest governmental advertiser in African American newspapers and are among the top advertisers on Black Entertainment Television.**
- **The Campaign's target is a one-for-one match; for every taxpayer dollar we spend, we require an added dollar's worth of anti-drug public service, *pro bono* activity.**
- **The Campaign's private sector match is now at the 109 percent level (or \$165 million) for the broadcast industry (matches of ad time on TV and radio). Overall, the corporate match for all Campaign efforts is at the 102 percent level (or \$175.4 million).**
- **Since last July, over 47,000 thirty second PSAs have run on television and radio because of the Campaign.**
- **In addition to the *pro bono* match, we have received over \$42 million of corporate in-kind support. Companies, such as Gateway and UPS, were quick to join our team.**
- **Thirty-two network television episodes have aired -- on the shows our young people most watch, using the stars they most know -- that have included the Campaign's strategic anti-drug message points.**
- **Our corporate efforts are as diverse as the rest of the Campaign. We have productive partnerships in place with BET, Univision, Telemundo, and numerous other specialized ethnic media outlets.**

The messages of the Media Campaign serve as a vital counter-force to the pro-drug use messages that buffet our children. For too long, the unfiltered Internet has been the media province of the

legalizers.⁹⁸ Legalizers not only use the Internet to push their policy views,⁹⁹ they also use it, for example, to tell young people specifically where the best drugs can be bought at the best price in their city.¹⁰⁰ Some of these websites even provide young people with direct access to drugs.¹⁰¹

However, today, through the Media Campaign, when a young person enters search words that relate to drugs -- from straightforward words like "marijuana" to slang, like "bud" or "stone" -- our advertising messages are keyed to respond with accurate drug prevention information. We are also developing web content that will give young people the information they need about drugs in a manner that is interesting and eye-catching. For example, working with Disney, a leader in reaching young people, we recently launched a new teen anti-drug website.

Our web presence is now substantial enough to balance that of the drug legalization community. For example, our two youth websites, "ProjectkNow" and "Freevibe.com" have respectively received 4,721,249 and 866,833 page views since each went online. Through web advertising (e.g., Internet "banner" ads) our Campaign has generated 221 million impressions.

Prevention, however, requires more than just mass media messages. Prevention begins with parents and families, and requires the support of schools and communities.

The most important tool we have against drug use is not a badge or a gun, it is the kitchen table. Parents can prevent drug use by sitting down with their children and talking with them -- honestly and openly -- about the dangers of drugs to young lives and dreams. While parents often doubt the impact they have on their children's drug use, the fact is young people listen to their parents. For example, recent study by the Partnership for a Drug-Free America found that 65 percent of young people (ages thirteen to seventeen) believe that "a great risk if you use marijuana is upsetting your parents."¹⁰² This same study found that 80 percent of our youth (ages thirteen to seventeen) believe that "an important reason for not smoking marijuana is so that your

⁹⁸See, e.g., Christopher Wren, *A Seductive Drug Culture Flourishes on the Internet*, The New York Times, June 20, 1997.

⁹⁹The New York Times has also documented at least one instance where groups promoting legalization called upon their counterparts to attack an anti-drug group by overwhelming its infrastructure through harassment calls. *Id.*

¹⁰⁰See "www.hypereal.org/drugs/price.report/u-index.html".

¹⁰¹See CESAR, *GHB and GHL: 10 Overdoses Reported in Past 90 Days in Maryland: Drugs Available on the Internet*, April 1999 (reporting sales of GHB and GHL over the Internet, with some of the trafficking websites registering more than 250,000 hits).

¹⁰²Partnership for a Drug-Free America, *Parents and Marijuana in the 90s*, Partnership Attitude Tracking Study 1997 (1997).

parents will respect you and will feel proud of you.”¹⁰³

To help parents we are reaching out -- across the Internet, in newspapers, on the airwaves, and through community groups -- to provide them with the information they need to be able to help their children make the right decision and stay drug-free. For example, through a Media Campaign alliance with AOL, we have created a Parents Resource Center, that can provide information at the click of the mouse. The Department of Education has also recently published *Growing Up Drug-Free: A Parents Guide to Prevention* to give parents the facts and arm them with what to say to their children.

As part of this comprehensive prevention framework, Secretary Riley has recently sent Congress the Administration's proposal for a revamped Safe and Drug Free Schools Program. If adopted this new program will improve accountability, require schools to adopt programs proven effective, and hold the entire system -- from the federal government to the local school -- accountable for producing real results for our children.

Through the Drug Free Communities Grant Program we are also providing local anti-drug coalitions with support in working to protect young people in their communities from drugs. In the first year of the program we made grants to 92 communities, from across 47 states and the District of Columbia. These groups are helping mobilize grassroots efforts to prevent drug use.

4. Combating Normalization

With attitudes being so critical in shaping drug use trends, it is vital that we ensure that drug taking never is perceived as “normal” behavior that is accepted or even tolerated by our society. The imperative to fight the normalization of drug use has played a critical role in the development of federal policies with respect to both medical marijuana and hemp.

With respect to medical marijuana, the recent Institute of Medicine (IOM) report, *Marijuana and Medicine, Assessing the Science Base*, is the most comprehensive summary and analysis of what is known about the medical use of marijuana.¹⁰⁴ The report emphasizes evidence-based medicine (derived from knowledge and experience informed by rigorous scientific analysis), as opposed to belief-based medicine (derived from judgment, intuition, and beliefs untested by rigorous science). ONDCP is delighted that the discussion of medical efficacy and safety of cannabinoids can now take place within the context of science.

The IOM report concludes that there is little future in smoked marijuana as a medically approved

¹⁰³ *Id.*

¹⁰⁴ Institute of Medicine, National Academy of Sciences, *Marijuana and Medicine: Assessing the Science Base* (1999).

medication.¹⁰⁵ Although marijuana smoke delivers THC and other cannabinoids to the body, it also delivers harmful substances, including most of those found in tobacco smoke. The long-term harms from smoking make it a poor drug delivery system, particularly for patients with chronic diseases. In addition, cannabis plants contain a variable mixture of biologically active compounds, therefore they cannot be expected to provide a precisely defined drug effect. Medicines today are expected to be of known composition and quality. Even in cases where marijuana can provide relief of symptoms, the crude plant mixture does not meet this modern expectation. If there is any future in cannabinoid drugs, it lies with agents of more certain, not less certain composition. The future of medical marijuana lies on classical pharmacological drug development.

The study also provides a detailed analysis of marijuana's addictiveness. It concludes that marijuana is indisputably reinforcing for many people. It states that a distinctive marijuana and THC withdrawal syndrome has been identified, but it is mild and subtle compared to the profound physical syndrome of heroin withdrawal. The study notes that few marijuana users become dependent but those who do encounter problems similar to those associated with dependence on other drugs. Slightly more than four percent of the general population were dependent on marijuana at one time in their life. After alcohol and nicotine, marijuana was the substance most frequently associated with a diagnosis of substance dependence.

In response to the study's recommendations that "clinical trials of marijuana use for medical purposes should be conducted," on May 21, 1999, the Department of Health and Human Services (HHS) released new guidance on procedures for the provision of marijuana for medical research purposes.¹⁰⁶ "To facilitate research on the potential medical uses of cannabinoids, HHS has determined that it will make research-grade marijuana available on a cost-reimbursable basis. . . . However, pursuant to this guidance, HHS will only provide research cannabinoids for studies that strictly meet the conditions contained in the guidance, including that such research must: meets good clinical and laboratory research practices; examine the use of cannabinoids only "in the treatment of serious or life threatening condition[s]"; and will address "unanswered scientific questions about the effects of marijuana and its constituent cannabinoids or about the safety or toxicity of smoked marijuana."

ONDCP endorses the Department of Health and Human Services' decision to facilitate further research into the potential medical uses of marijuana and its constituent cannabinoids. Such research will allow us to better understand what benefits might actually exist for the use of cannabinoid-based drugs, and what risks such use entails. It will also facilitate the

¹⁰⁵*Id.* at 7.

¹⁰⁶Department of Health and Human Services, Announcement of the Department of Health and Human Services Guidance on Procedures for the Provision of Marijuana for Medical Research, May 21, 1999.

development of an inhaler or alternate rapid-onset delivery system for THC or other cannabinoid drugs. Advisors to both the National Institutes of Health and the Institute of Medicine have concluded that such research is warranted. This decision underscores the federal government's commitment to ensuring that the discussion of the medical efficacy and safety of cannabinoids takes place within the context of medicine and science.

Research toward the development of cannabinoid-based medicines is a medical and scientific question that America's health and science establishment must address. However, there are those who want to use medical marijuana as a wedge issue to drive open a hole in counter-drug programs. For example, Richard Cowan, a member of the Advisory Board of an advocacy group called the "Drug Policy Foundation," in 1995 stated: "Key to legalization is medical access [to marijuana] because once you have hundreds of thousands of people using marijuana medically under medical supervision, the whole scam is going to be blown. Once there is medical access and we continue to do what we have to, and we will, we'll get full legalization."¹⁰⁷

While we must exercise compassion and move ahead with the development of treatments that can relieve human suffering, we cannot and will not allow progress on the medical front to jeopardize the futures of millions of young people.¹⁰⁸ Regardless of developments with respect to the use of cannabinoid-based medicines, we will continue to fully enforce the full range of Federal laws pertaining to the non-medicinal use of marijuana.

We face a similar challenge with hemp. Growing numbers of farmers, rightfully or wrongfully, believe that hemp may offer a new crop that can help the farm economy. However, there are those who want to use de-regulation of hemp to erode America's disapproval of drugs. Still others with criminal intent see hemp as providing a new way to conceal the production of marijuana plants.

If we allow farmers to test the viability of this crop in the marketplace, we must not do so in a manner that allows the normalization of marijuana. Products that market their hemp content with marijuana leaves do so only to sell their products relationship to marijuana. The appeal of these products is not that they are made of hemp but that they are marijuana-related. The hype built around these marijuana-related products serves only to glamorize the counter-culture appeal of a drug that has serious consequences for our young people who use it. We cannot allow our policies toward hemp to directly or indirectly increase the use of marijuana among our youth.

¹⁰⁷See State of Oregon, *Medical Marijuana: A Smoke Screen* (1997) (videotape).

¹⁰⁸The impacts of marijuana use on a child's development are well documented. For example, according to the *National Household Survey on Drug Abuse* child (ages 12 to 17) who regularly uses marijuana is roughly 5 times more likely to assault someone, 6 times as likely to steal, and 6 times as likely to cut classes, as a peer who has never tried the drug.

America's farmers, who have long been among the most steadfast supporters of our counter-drug programs, will help us police their own. Similarly, ethical farmers seeking solely to make an honest living off a viable legal crop should be more than willing to take the necessary security steps to provide the public with confidence that they are growing hemp and not marijuana.

5. Expanding Treatment

Drug treatment is proven to reduce drug use, drug-related crime, and other related social ills. Studies show that for people who have successfully completed a drug treatment program, even one year after treatment, drug use drops 50 percent, illicit activity falls by 60 percent, drug selling drops by nearly 80 percent, arrests fall by more than 60 percent, homelessness drops by 43 percent, dependence on welfare decreases by 11 percent and employment increases by 20 percent.¹⁰⁹ In short, treatment works.

Our FY2000 counter-drug budget requests \$3.5 billion for drug treatment and treatment research programs, representing a 5.5 percent increase from our FY1999 budget. Overall, assuming our FY2000 request is approved, we will increase federal spending on treatment by 25 percent since FY1996. Yet, we still have a long way to go to close the treatment gap. In 1996, approximately 4.4 to 5.3 million people were estimated to need drug treatment.¹¹⁰ Slightly less than two million people currently receive drug treatment.¹¹¹ These figures show that we continue to have a significant treatment gap. Expansion of the Substance Abuse and Mental Health Services Administration's drug treatment and block grant programs, as called for in the Administration's proposed counter-drug budget, will add much needed treatment slots. However, even these gains will not nearly close the current treatment gap.

In a move that will help close this gap, on June 7, 1999, the Office of Personnel Management sent a letter to the 285 participating health plans of the Federal Employee Health Benefits Plan informing them that they will have to offer full mental health and substance abuse parity¹¹² to participate in the program. This step will provide full parity for nine million beneficiaries by next year and will ensure that the Federal government leads the way in providing parity.

¹⁰⁹National Institute on Drug Abuse, Drug Abuse Treatment Outcome Study (1997); Department of Health and Human Services, National Treatment Improvement and Evaluation Study (1996).

¹¹⁰ONDCP, *The 1999 National Drug Control Strategy*, at p. 87, n. 19 (1999).

¹¹¹*Id.* at p. 57.

¹¹²The Administration's goal for the FEHB is to make plan coverage for mental health and substance abuse care identical to traditional medical care with regard to deductibles, coinsurance, copayments, and day and visit limitations.

Additionally, we are developing new guidelines for methadone treatment, which will expand access to this treatment for those who can benefit from it. These new guidelines will also improve the quality of methadone treatment programs by shifting them to a clinic-based modality. Properly administered, methadone treatment can offer drug-addicted people an important bridge to a drug-free lifestyle. By expanding and improving on existing methadone treatment programs we can offer addicted individuals the hope of a brighter, more productive, drug-free future.

6. Breaking the Cycle of Drugs and Crime

Drug dependent people are responsible for a disproportionate amount of our nation's crime. According to the 1998 ADAM report, roughly two-thirds of adult arrestees and more than one-half of juvenile arrestees tested positive for at least one illicit drug.¹¹³ In 1997, one-third of state prisoners and about one-in-five federal prisoners said they had committed the offense that led to their imprisonment while under the influence of drugs.¹¹⁴ Nineteen percent of state inmates said they perpetrated their current offense leading to incarceration in order to obtain money to buy drugs.¹¹⁵

Drug-law offenders are filling our nation's prisons and imposing tremendous correctional costs on our society. The nation's incarcerated population is now over 1.8 million people. Under the present system, far too many addicted individuals enter the cycle of drugs, crime, and prison only to spend the rest of their lives caught in this cycle.

We cannot arrest our way out of our nation's drug problem. We need to break the cycle of addiction, crime, and prison through treatment and other diversion programs. It costs the American taxpayer \$25,000 a year to imprison a drug-addicted criminal.¹¹⁶ By comparison, a year of outpatient treatment costs less than \$5,000, and the cost of even more comprehensive residential treatment programs range from \$5,000 to \$15,000 per year.¹¹⁷ Evidence also shows that drug treatment programs are effective at reducing crime. For example, treatment programs administered by the Delaware Department of Corrections have reduced the recidivism rate for

¹¹³See Arrestee Drug Abuse Monitoring Program, National Institute of Justice, 3 (1998).

¹¹⁴Christopher Mumola, *Substance Abuse Treatment, State and Federal Prisoners, 1997*, (1999) (published by the Bureau of Justice Statistics).

¹¹⁵*Id.*

¹¹⁶*Id.*

¹¹⁷*Id.*

drug-related crimes by 57 percent.¹¹⁸ Birmingham, Alabama's "Breaking the Cycle" program is also producing promising results. Since its inception in June of 1997, two thousand offenders successfully completed this program as a condition of their release. To date, their rearrest rate is about 1 percent.¹¹⁹ Breaking the cycle -- through diversion programs and treatment -- is not soft on drugs, it is smart on defeating drugs and crime.

In 1991, the number of federal inmates receiving substance abuse treatment numbered only 1,236. By 1998, that number reached 10,006. While this is a substantial step forward, it is still only a first step. We estimate that the number of arrestees who require drug treatment may be as high as two million a year.¹²⁰ If we are to reduce the burdens of drugs and crime on our nation, we need to expand dramatically the treatment opportunities in the criminal justice system.

Similarly, we also need to expand the number of drug courts, which offer nonviolent drug-law offenders supervised treatment in lieu of jail. Defendants who complete a drug court program either have their charges dismissed or probation sentences reduced. In 1994, there were roughly a dozen drug courts nation-wide. In October 1998, 323 drug courts were operating nationwide, and more than two hundred were in planning stages.¹²¹ Even with their growing numbers, today's drug courts still only reach 1 to 2 percent of the population of nonviolent drug offenders.¹²²

The counter-drug budget now before the Congress seeks to expand current programs in both of these areas. The Administration's request seeks an additional \$100 million to provide drug abuse assistance to state and local governments in developing and implementing comprehensive systems for drug testing, treatment and graduated sanctions for drug offenders. The request also seeks an added \$10 million for drug court programs, to bring the total support for these programs to \$50 million in FY2000.

¹¹⁸James Inciardi, *et al.*, *An Effective Model of Prison-Based Treatment for Drug-involved Offenders*, 2 *Journal of Drug Issues* 261-278 (1997).

¹¹⁹ONDCP, *The 1999 National Drug Control Strategy*, at p. 64 (1999).

¹²⁰*Id.* at p. 63.

¹²¹*Id.* at p. 64.

¹²²*Id.*

7. Helping Communities Fight Drugs

The High Intensity Drug Trafficking Area (HIDTA) program provides assistance to regions of the nation with critical drug trafficking problems that impact wider areas of the nation. HIDTA funds support expanded cooperation between federal, state and local law counter-drug enforcement authorities. HIDTAs strengthen America's drug control efforts by forging partnerships among federal, state and local agencies; and facilitating cooperative investigations, intelligence sharing and joint operations. There are presently 21 HIDTAs. Through funds provided by the Congress in our current budget, soon we will announce the creation of five new HIDTAs.

Local counter-drug law enforcement also benefits greatly from federal efforts to increase the number of police officers on our streets and better equip them to combat today's high-technology drug traffickers. The Community Oriented Policing Services program, known as COPs, has funded over 92,000 new and redeployed police officers to help protect our communities and streets. Through the work of the Counter-drug Technology Assessment Center (CTAC) we are also helping local law enforcement authorities obtain the most up-to-date drug fighting tools.¹²³

8. Strengthening the Southwest Border

The shared two-thousand-mile border with Mexico attracts drugs and provides Mexican drug traffickers ample opportunity to move large quantities of heroin, cocaine, marijuana, and methamphetamine into the U.S. Drug violence spills over this border into the neighboring states -- New Mexico, California, Texas, Arizona. Drugs that cross this border pass into our heartland (into Kansas, Iowa, Illinois) and beyond (Massachusetts, New York, Oregon) and attack cities, suburbs, and rural communities alike.

Improving our counter-drug efforts along this border first requires us to better organize our existing efforts. We need to improve our chain of command and accountability for programs in this region. Our Southwest Border programs must also become more flexible and intelligence-driven. We need to better understand the emerging threats and deploy our resources to counter these threats.

We also must shift from a system that is dependent upon manpower to one that relies on cutting-edge technology. We simply cannot think that in an era of expanding interchange that we will be able to unpack every crate of carrots or search every railcar by hand. We need to develop and deploy a family of complementary systems within the next five years that can inspect increasing numbers of in-bound containers, shipments, and conveyances for drugs. We want to provide major ports of entry with the capacity to subject in-bound shipments to non-intrusive inspections

¹²³On the demand-side, CTAC technology development efforts are also at the forefront of efforts to better understand the disease of addiction and to develop cures for drug problems.

by complementary systems. Through technology, we shall put in place a seamless curtain against drugs. This curtain will not be iron but information -- derived from technology and intelligence. It will be held in place by good organization and shared commitment -- a commitment based on common values and interests. It will be permeable to trade and culture but impermeable to drugs, crime, and violence.

9. Attacking Drugs in the Transit Zone

Transit zone interdiction plays a critical supporting role to source country programs. Transit zone interdiction programs remove significant amounts of illicit drugs from the pipeline each year that would otherwise reach the United States. These efforts also raise the costs and risks to traffickers of moving cocaine into the United States. Additionally, interdiction operations in the transit zone produce information that can be used to attack trafficking organizations, thereby strengthening the overall U.S. law enforcement effort against international crime. Transit zone interdiction programs reinforce international, bilateral, and regional cooperation against the threat of illegal drugs and strengthen the capabilities of transit nation law enforcement institutions.

Drug traffickers are adaptable, reacting to interdiction successes by shifting routes and changing modes of transportation. Large international criminal organizations have extensive access to sophisticated technology and resources to support their illegal operations. The United States must surpass traffickers' flexibility, quickly deploying resources to changing high-threat areas. Consequently, the U.S. government designs coordinated interdiction operations that anticipate shifting trafficking patterns.

Drugs coming to the United States from South America pass through a six-million square-mile transit zone that is roughly the size of the continental United States. This zone includes the Caribbean, Gulf of Mexico, and eastern Pacific Ocean. The Coast Guard is the lead federal agency for maritime interdiction and co-lead with U.S. Customs for air interdiction. The interagency mission is to reduce the supply of drugs from source countries by denying smugglers the use of air and maritime routes in the transit zone. In patrolling this vast area, U.S. federal agencies closely coordinate their operations with the interdiction forces of a number of nations. In 1998, roughly eighty metric tons of cocaine were seized in the transit zone.

Stopping drugs in the transit zone involves more than intercepting drug shipments at sea or in the air. It also entails denying traffickers safe haven in countries within the transit zone and preventing their ability to corrupt institutions or use financial systems to launder profits. Consequently, international cooperation and assistance is an essential aspect of a comprehensive transit zone strategy. Accordingly, the United States is helping Caribbean and Central American nations to implement a broad drug-control agenda that includes modernizing laws, strengthening law-enforcement and judicial institutions, developing anti-corruption measures, opposing money laundering, and backing cooperative interdiction.

The Caribbean Violent Crime and Regional Interdiction Initiative will expand counter-drug operations targeting drug trafficking-related criminal activities and violence in the Caribbean region including South Florida, Puerto Rico, the U.S. Virgin Islands, and the independent states and territories of the eastern Caribbean. This initiative will implement mutual cooperative security agreements between the United States and Caribbean nations, implement commitments made by the U.S. President during the Caribbean Summit held in Barbados in May 1997, develop regional maritime law enforcement capabilities; increase the capability of Caribbean nations to intercept, apprehend, and prosecute drug traffickers through modest expansion of training, equipment upgrades and maintenance support, and institutionalize the Americas Counter Smuggling Initiative (ACSI) to provide at-risk commercial carriers, industry, and government offices with training to prevent goods and conveyances from being used to smuggle illegal drugs.

Nonetheless, traffickers have demonstrated that they can absorb interdiction losses in the transit zone as the cost of doing business while increasing source country cultivation and production to make up interdiction losses. In the transit zone, traffickers have the initiative and can choose when, where, and how to challenge interdiction forces. They are able to alter routes and methods in response to effective law enforcement interdiction activity. Transit zone operations will be most effective when source country programs are able to effectively constrain drug production potential, preventing trafficking organizations from making up interdiction losses.

10. Building International Cooperation

The United States continues to focus international drug control efforts on supporting the critical work of drug source countries. International drug trafficking organizations and their production and trafficking infrastructure are most concentrated, detectable, and vulnerable to effective law enforcement action in source countries. The coca and opium poppy growing areas are easily detectable and relatively fixed. The cultivation of coca and opium poppy and production of cocaine and heroin are labor intensive and can be disrupted by concerted law enforcement action.

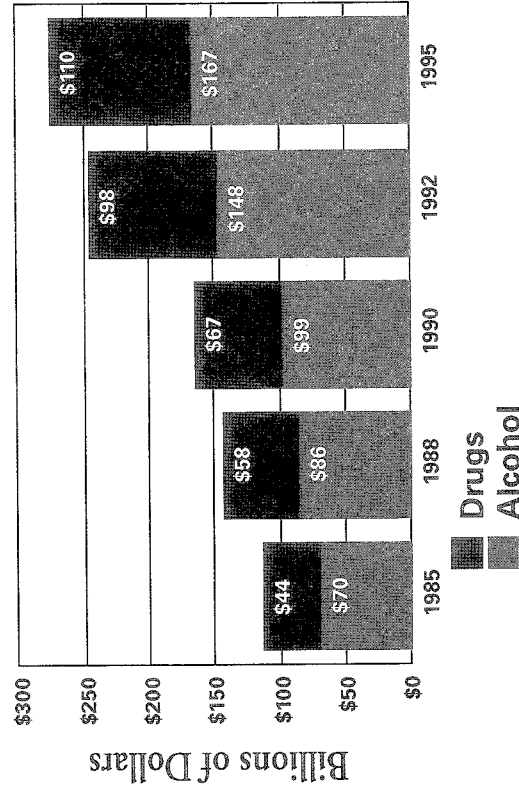
To be successful on the scale necessary to disrupt the illegal drug industry, drug source countries must have control of growing areas, adequate law enforcement resources, capabilities, and the will to confront a sometimes politically powerful segment of the population or one that is protected by well-armed and well-equipped insurgent groups. The international drug control strategy seeks to bolster source country resources, capabilities, and political will to reduce cultivation, attack production, and disrupt and dismantle trafficking organizations, including their command and control structure and financial underpinnings. Our actions focus on assisting the host nation expand law enforcement control over drug crop growing areas, reestablish the rule of law, and eliminate illegal drug crops in ways that protect human and democratic rights. The political will and long-term commitment of these other nations are critical to our common success against drugs.

1999 National Drug Control Strategy Goals

- Goal 1: Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.**
- Goal 2: Increase the safety of America's citizens by substantially reducing drug-related crime and violence.**
- Goal 3: Reduce health and social costs to the public of illegal drug use.**
- Goal 4: Shield America's air, land, and sea frontiers from the drug threat.**
- Goal 5: Break foreign and domestic drug sources of supply.**



The Social Costs of Drug and Alcohol Abuse



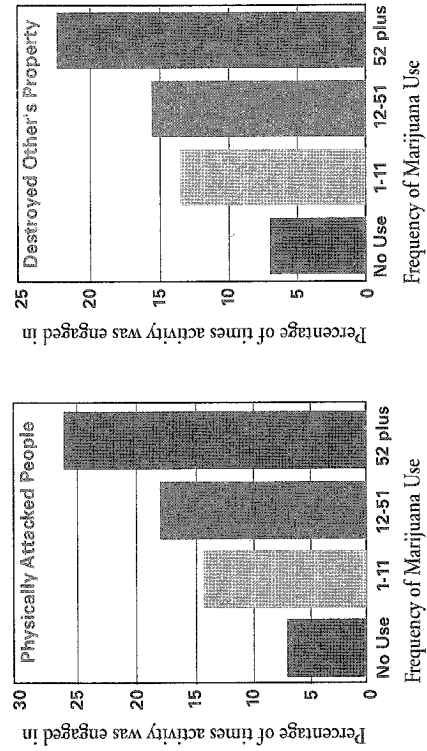
Sources: Rice et al., 1990; Robert Wood Johnson Foundation, 1993; National Institute on Drug Abuse & National Institute on Alcohol Abuse and Alcoholism, March, 1998

ONDCJ-64609



Aggressive Anti-Social Behavior is Clearly Linked to Marijuana Use

Percentage of those ages 12 to 17 who reported aggressive behavior in past 6 months, by number of days marijuana was used in the past year

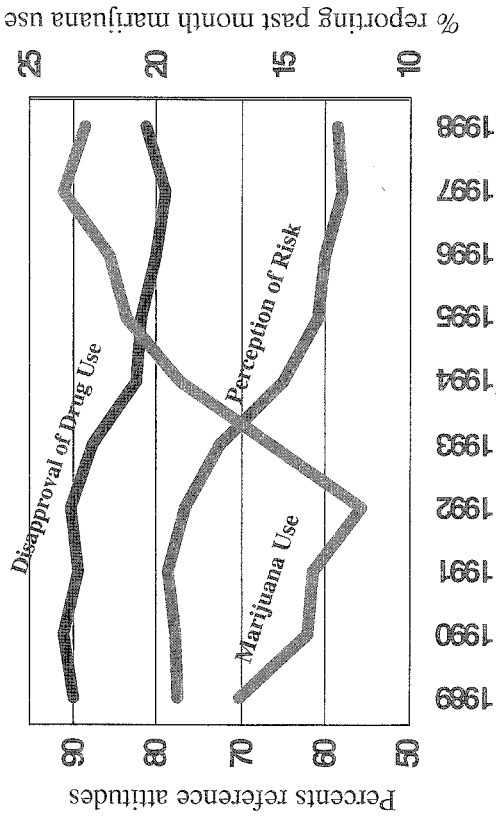


Source: NHSDA Household Survey Data, 1994-1996

ONDCP-01-039



Youth Attitudes Drive Drug Use



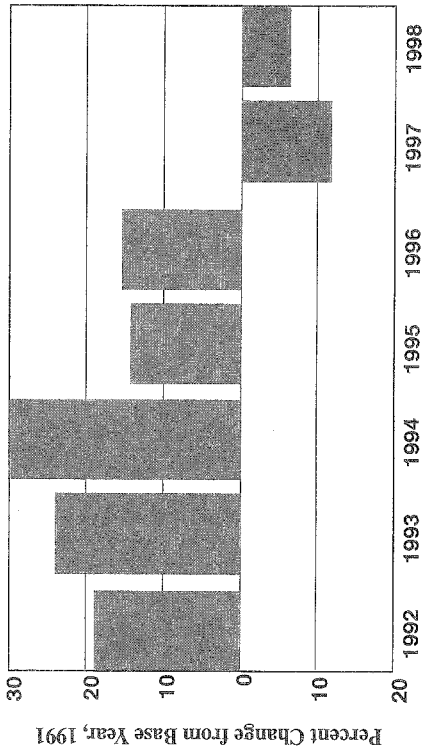
Source: 1998 Monitoring the Future Study

ONDCJ 61699



1999: A More Optimistic Situation Among Our Youth

*Annual Change (in percentage) in 30-day
Drug Use Rates Among 8th Graders*



Source: 1998 Monitoring the Future Study

ONX07-6(6-99)



Cyberspace Challenges

www.skeenville.com

Buy a Bong

www.lycaenum.org

Cook Crack

www.overthrow.com

Make Meth

www.alcohol.nl

Buy Seeds

www.hyperreal.org

Drug Buying Tips

www.cannabis.com

Beat a Drug Test

6/16/99



ONDCP'S Internet Strategy

- Combat misinformation and glorification of drugs.
- Establish visible, credible, and helpful on-line alternatives.

www.whitehousedrugpolicy.com

www.freevibe.com

www.projectkNOw.com

Drug Resource Center (AOL)

868,000 visits

4,721,000 visits

252,000 visits

- Banners on search engines and web pages:

Yahoo, Warner Brothers, AOL, Comedy Central,
Sony Online, Discovery Channel, Disney

General McCaffrey. Some quick comments if I may, Mr. Chairman.

To what extent is there a drug legalization movement in the United States? If you try to overtly move that argument forward, it is very difficult to do. There are probably around 400 groups in America that we can identify, sort of a superficial Lexis-Nexis check, that are advancing that argument.

To put that in context, we have brought together 47 national civic, service, fraternal, veteran's and women's organizations in something we call Prevention of Drug Abuse Through Service. That represents 100 million people and a million chapters. Those are people, American citizens, who have stated publicly that we are opposed to drug abuse. There are 121,000 local Boy Scout units, 4,000 plus community antidrug coalitions, 2,300 local YMCA chapters, et cetera. Though I would argue, if you look out at America, the 270 million of us, there is unanimous opposition to the notion of making these drugs more available to our children.

The second thought I would table for you is we should make people stand upon their written record. If you write a book, if you write an article, if you give a speech and advance an argument in favor of drug legalization, you should not be allowed later to move to a disguised position. I have provided previously to the committee excerpts from some of the books and writings that I think make this point.

Ethan Nadelmann said, "personally when I talk about legalization, I mean three things. The first is to make drugs such as marijuana, cocaine and heroin legal. I propose a mail order distribution system based on the right of access."

Professor Arnold Trebach out at American University: "under the legalization plan I propose here, addicts would be able to purchase the heroin and needles they need at reasonable prices from a non-medical drugstore."

Now, we have been culling this kind of material out. We ought to be civil, we ought to be charitable and have democratic debate, but some of these notions are sheer buffoonery. They are from an ivory tower. They are not informed on the kind of problem that I see at face value, in prisons in America, in drug treatment centers, in families and in the workplace. I think we need to strip away the disguise and label people with the arguments they are actually trying to support.

I believe the American people support our strategy against drugs. According to the 1999 Gallup poll 69 percent firmly oppose any legalization of marijuana. The 1998 Family Research Council poll, indicated that 82 percent oppose making drugs legal like alcohol.

I think we also have some examples where we can look around the world. We can look at the Dutch example. The European Monitoring Centre notes that heroin addiction has tripled since the Dutch liberalized their policy. Holland is now a synthetic drug production center.

Our own experience in the United States in the 1800's when legal opium use was available, we had our own use rates jump 400 percent.

I think we also should take into account that drug abuse is not just a personal choice. It involves other people. We look at child

abuse and neglect and other innocent victims. We find that substance abuse exacerbates 7 of 10 child abuse and neglect cases. We look at workplace accidents. We believe that a third of the industrial accidents in America are caused by illegal drug use. We look at drunk driving and find the enormous correlation between the use of illegal drugs and alcohol in fatal accidents on the Nation's highways.

The bottom line is we are absolutely opposed to the legalization of these substances or their de facto legalization under the notion of harm reduction. It is really unfortunate that they have captured that term. I would like to introduce Bridgette Grant, a senior at George Mason University—thanks for being here—she is one of our interns and will help me with these charts.

If you look at our National Drug Control Strategy and what we are trying to accomplish, goals two and three are, in fact, a harm reduction approach. We recognize that 4 million plus chronically addicted Americans are killing 14,000 people a year and causing \$110 billion of damages. Smart law enforcement and smart drug treatment have to deal with that huge number of Americans, a tiny percentage of the population. Unfortunately the harm reduction label has been hijacked by people that in many cases are actually talking about the legalization of drugs.

I also have to underscore, our strategy does say you can't hope for a magic solution on drug abuse. Clearly, our dominant objective is prevention, education aimed at American adolescents. We are trying to get kids from the age of 9 through about 19 where we minimize their exposure to gateway drug-taking behavior. That certainly includes alcohol and cigarettes. Primarily it is marijuana and huffing inhalants and heroin and almost any drug you can name—Ecstasy and MDMA are now spreading up and down the eastern seaboard.

Bridgette, if you will, the next chart.

A quick chart, what are the consequences? Is this an individual choice? Can we buy a libertarian model or should we be forced to recognize even though drug abuse in America has come down dramatically in the last 15 years, if you look at 1979, 14 percent of the population was using drugs. In 1992 it dropped to 6 percent. We are going to try and take it below 3 percent. But that has nothing to do with the fact that we have 4 million Americans who are sicker than ever committing enormous amounts of crime and they dominate the population behind bars, 1.8 million Americans and growing; and probably between 50 and 80 percent of those people have a chronic drug or alcohol problem.

That is the cost to you and I. This is not an individual choice. This involves our workplaces, our children, and our communities.

Bridgette, next chart.

Let me, if I may, underscore this chart. There has been a notion of hard drugs and soft drugs. We understand that heroin, methamphetamines, and crack cocaine have consequences that are more severe than the softer drugs of MDMA, marijuana, et cetera.

I think the strongest voice I listen to inside the administration is Donna Shalala, who is essentially a teacher, a college professor, a university president. We are adamantly opposed to the use of

marijuana in America, whether that is on the Nation's highways or, more importantly, among our students and our families.

When you look at some of the behavior that Dr. Leshner can speak to, where you find high rates of marijuana abuse, you find enormous statistical correlations to other behavioral problems, one of which is violence. It is not just crashing your car or an 18-wheeler. It is also personal aggressive behavior.

We are not suggesting we have demonstrated a causal linkage. I am just saying that is there. If your child is involved in a lot of drug abuse, including marijuana, it will probably also have beer involved. You have problems. Part of it is aggressive behavior.

Next chart, please. You have seen this chart before, but it deserves to be restated.

We believe, and this chart comes out of the University of Michigan data, but it underscores a notion that attitudes drive behavior. When youth attitudes about drug abuse change, when they worsen, when they see it as less threatening, more acceptable; they use more drugs. When they turn those attitudes around, drug abuse goes down. That is why we are so grateful for the bipartisan support we have gotten on this National Youth Anti-Drug Media Campaign.

We believe you have to talk to children, not just over TV, the Internet, and the radio. It has to be parents, educators, coaches, pediatricians, and local law enforcement.

We are seeing the initial stages of turning youth attitudes around in America. For 5 years, it went in the wrong direction. In the last 2 years, we have seen it stabilize and then modest but statistically significant reductions in drug abuse in America concerning 8th grade, 10th grade, 12th grade, with cigarettes, alcohol, marijuana and other drugs. We have 10 years of hard work ahead of us if we are going to capitalize on this beginning effort.

Next chart. We have been playing around with this chart to make a point.

Take 1991 as a baseline year; 1991 was the year before actual youth rates of drug abuse started up. We had a long period where it came down from the disaster in the 1970's. Attitudes started changing in probably 1990, fear of drug use in 1991. In 1992, drug use rates went up. So I took 1991 as a baseline year. Those are increases or decreases in a given year. The last 2 years, we have the beginning indications that when America's communities and families and educators get involved, we actually can talk to our children and turn the situation around. But I would not even indicate this is the beginning of a victory. It just indicates that our hard work can pay off.

Next chart.

I am not going to go through this in much detail, but it is just astonishing what is on the Internet. It is unbelievable. When we tried to name one of our initial home pages Project Know, K-n-o-w, I had initially asked for Project Teen. When we went to that key word on the net, you get masses of child pornography. When you fed in drug search words—marijuana, heroin, et cetera—you ended up on drug legalization sites. They are linked together. It is incredible.

The High Times home page. They are selling drugs over the Internet. They are selling doping materials for young athletes over the Internet, and they are providing credibility and an argument that these materials don't cause physical harm.

We are going to try and counter that, but you need to understand that it is out there, and it is incredible, the material that many parents aren't aware their children see and encounter in the computer they have in their room or basement.

Next chart.

We are now out there confronting that issue. We have done some incredibly good work on this. I have two very sophisticated firms, Ogilvy Mather and Fleishman Hillard, that are helping guide our media buying campaign, but when it comes to the Internet itself, we have provided you all of our linked home pages. I just tell you we are up to almost a quarter of a million hits on our White House Drug Site. Disney is running Freevibe.com. Just since March—many of you were there when we opened that—they are pushing a million hits. We are almost up to 5 million visits on Project Know; we are up to a quarter of a million on the Drug Resource Center, America Online, just since the beginning of April.

We are also influencing all the search engines and webpages. If you punch in on Yahoo, Warner Brothers, AOL, et cetera, key words, you will end up getting scientifically, medically accurate information that is in color, that is interactive. If you are a mother, you can go to Drug Help AOL. If you are a teen, you can go to Freevibe.com. You can see pictures of this material, you can talk to personalities, public people, movie stars, about why drug abuse is harmful to your future.

We think we are starting to move ahead, and we welcome your own involvement in that.

Mr. Chairman, if I may, let me just end my formal comments there, but I thank you and your committee members for your leadership in bringing this issue to the attention of the American people.

Mr. MICA. Thank you, General.

Mr. MICA. I would like to start off with a couple of questions, if I may.

First of all, General, I have a bibliography here of more than 200 scientific studies indicating the extraordinary damage that is done to the human body and the brain by marijuana, probably from some of the most renowned scientific minds in the world. The findings they come up with are absolutely uncontestable, that THC and marijuana damage the brain, the lungs, the heart, and the reproductive and immune systems. They also show that marijuana is linked to increased aggressive and violent behavior.

In view of these findings, why do you believe there is still a fiction that is prevalent out there particularly among our kids that taking drugs is fine and safe, that use of marijuana is not dangerous or harmful?

General McCaffrey. Dr. Leshner will probably want to talk to the medical issues. I am normally trying to be careful on how I pose this.

What we are sure of is that if your 12 year old adolescent is using marijuana on weekends, they are probably in a period of

enormous vulnerability, central nervous system development, social development, and educational development. If they get involved in that behavior younger, and they do a lot of it, the chances of them being in trouble are significantly enhanced.

You can argue about what the stats are. The statistic I use is that at age 12, if you are smoking pot on weekends, you are 80 times more likely to end up using cocaine than some 12-year-old who isn't smoking pot. Dr. Leshner in the years to come possibly will document that 15 percent of that population in the high school years will end up dependent upon marijuana if they use a lot of it. That figure is soft.

Now, to a high school kid, this might sound like pretty good odds. To your mother or the coach, it sounds like dreadful odds—15 percent chance of being in serious, possibly lifelong, trouble. It is a complicated challenge.

A third of adult Americans have used an illegal drug. It is age dependent. There are some demographics tied into it. The lowest rates of drug abuse in American society are African Americans under the age of 30. But depending on your year, group, and college yes/no, the chances are you smoked a joint. Thirty million Americans have been exposed to cocaine. They have stopped it. They don't want to do it. But now they are trying to sort out in their own mind what they tell their kids.

We have been remiss in not explicitly telling our children that, regardless of mother's and my background, in this family we are not going to drive drunk, smoke dope, or use inhalants. These are behaviors that we have learned are destructive to your future. I think the message has been too weak. That is the answer, Mr. Chairman.

Mr. MICA. You have described in the past, when you were speaking about medical marijuana, I think the term you used, you called it "a stalking horse for legalization." General, many of those who are trying to promote legalization have started with promoting the medical use of marijuana. Can you tell me how your office has tried to deal with that issue?

Also, we have a problem that we have lost in many of the States where this issue is on the ballot. Tell me, you have said this is "the stalking horse for legalization," and I think you have just defined this as a serious drug problem. What has been done by the ONDCP to deal with this situation?

General McCaffrey. Three years ago, I consulted with the people who I think know what they are talking about—Dr. Leshner, Dr. Harold Varmus, Dr. Nelba Chavez—the folks who have devoted their lives to a study of drug addiction. We came to a conclusion that we were getting, to be honest, rolled in the public arena by some very clever people who were hiding behind medical use of illegal drugs and were actually pushing a drug legalization agenda.

But if there is one thing I know about and respect, it is American medicine. I have spent more time in hospitals as a patient than most young doctors have worked there. We have great trust in American medicine and in the process under the NIH and the FDA by which we make medicines available as clinically safe and effective. We trust doctors. We give them morphine. We give them heart medicines that can kill you.

So what we did is, we said, let's go out and we hired the American Academy of Sciences, gave them \$800,000 for a study to review what we know and do not know about smoked marijuana. We have a document that is done by serious people that we can stand behind. That document says smoked marijuana ain't medicine. It is a carcinogenic delivery vehicle, it is unknown dose rates, it is 400 plus compounds, it is 30 plus cannabinoids. It won't be medicine. It has a potential modest contribution to some symptom management. It has no curative impact at all.

It also went on to say, why don't you go research more of the cannabinoids? There is one right now, THC, available in a pharmacy. Maybe others could have benefit, particularly in combination with other therapies. From a policy perspective, I support such a research approach.

Finally, it said, you need a rapid onset delivery vehicle. We will go ahead and support that notion. That means deep lung inhalants, nasal gels, skin patches or suppositories. But what we have to do is keep that issue with doctors and scientists and not let it become a political issue.

We have a problem. Five States, as I remember, and possibly the District of Columbia through some very clever investment of advertising dollars, have now passed some form of medical marijuana initiative, and it is State law. We are trying to confront that in a prudent manner, to take into account the State-Federal sensitivities.

These drugs are still not certified for medical prescription. It is illegal under Federal law to grow, produce or sell marijuana, and we will uphold the law.

Mr. MICA. Two final questions, and I want to give my other colleagues ample opportunity for questions.

First of all, has your agency researched whether the Federal Government can preempt efforts to make drugs such as marijuana and their medical use illegal in the States? That is the first question.

Second, you spoke to money coming into these referendums. We have some documentation that Mr. Soros, George Soros, a multimillionaire—incidentally, I invited him to testify today and will invite him back because we are interested to find out his motivation and what is going on here—he created the Lindesmith Center and funded it with \$4 million. He has also given \$6.4 million, we believe, to the Drug Policy Foundation, a legal advocacy group for medical marijuana.

Two questions again. One, can we preempt State efforts? The second part of the question: Here is one individual. I am not sure what his end game is. Maybe you have some insight as to the motivation for his money and where this money is coming from to promote these initiatives and pass them? Those are my two final questions.

General McCaffrey. Mr. Chairman, I would ask for your permission to give you a written answer on the legal political notion of preempting States.

Let me tell you the answer as I understand it. These statutes were deemed to not be in conflict with Federal law; and so the up-front answer is, it is still against Federal law to grow marijuana,

possess it, sell it or write a prescription for medical purposes. It is against the law. We will uphold the law.

Having said that, there are 7,000 DEA agents, a couple of thousand staff, they are in 40 nations on the face of the Earth. Criminal justice is a State responsibility almost across the board. We have a problem here. We are going to have to sort it out. The lead of solving the problem has to be the people of California, Oregon, the State of Washington, Arizona, Hawaii, et cetera.

I would be glad to provide you perhaps a more definitive legal argument, but there is no conflict with Federal law, and we will enforce Federal law.

The motivation of people behind these efforts, I think there is probably a range of behaviors. Some of them are patently personal, using drugs and trying to advance their own use. I think that is probably not the motivation for many of them. A couple of them have intellectually goofy positions.

Professor Trebach at American University, and I don't mean to be uncharitable, but I don't think he has thought through the argument that he is hoping to see a return of opium dens in America and to contrast that with the evil of the bar, the saloon.

I think there is a great sadness on the part of many of us in America about this small percentage of the population, the huge consequences we pay. Congressman Hutchinson talked about, if you have a family member that is abusing drugs, is this a war?

One of my best friends and his wife, whom I believe you know, a very senior military officer, his 21-year-old baby is now sitting in a wheelchair with permanent short-term and long-term cognitive impairment, with massive muscle loss in the right arm and right leg because he overdosed on Mexican black tar heroin and was in a coma for 42 days. This has devastated the family.

When we announced our last pulse check in an emergency room in a New York City hospital and got these beautiful physicians to talk about what they see in drug abuse in America, and it is absolutely ugly, I don't think Mr. Soros and some of these other people have seen that, and I don't think they appreciate the consequences. They are hopeful from an elitist standpoint that maybe it is some lower class kind of person that is involved in this behavior, not my family, not my community. If you just legalized it, it would all go away.

As we have tried to advance in that paper that Rob Housman and Pancho Kinney from my strategic planning shop wrote, nothing could be farther from the truth. The problem with drugs isn't that they are illegal. They are destructive of the human body, of brain function, and of spirituality. That is the problem with drugs.

Mr. MICA. Thank you.

I would like to yield now to our ranking member, Mrs. Mink.

Mrs. MINK. I thank you.

There is hardly a word, General McCaffrey, that you have stated today that I don't agree with totally. Unfortunately, however, we are faced with this nagging debate about marijuana. I don't think there is any argument about any of the other drugs with reference to legalization. At least I haven't heard it in any of the constituent groups in my own State that are talking about legalization. It is primarily concentrated in this area of marijuana.

I think one of the important areas that we have to examine is the effect of marijuana on the human brain, bodily functions on all the other aspects of being a total person. And until we do that, until the scientific research comes up with that specific, unequivocal statement about the damage that a person can suffer as a result of the use of marijuana, we are going to have this continuing debate.

There is absolutely no doubt that those who use marijuana are likely to go on to other drugs, but that is a different issue. We can certainly point that out to young people who are tempted by marijuana, that this is a dangerous road because it leads to other addictions. We can certainly talk about the criminal implications that come from the use of marijuana.

And all of that should militate against a society that tolerates the use of marijuana. But until we can get this definitive study with respect to the use of marijuana and the harm that comes from that in terms of being a fully cognizant, social, intelligent human being with total brain capacity, I think that we are challenged; and I would like to hear your comments about that. Because that is the only element that I feel is missing in the debate in which I find myself having to endure in many, many places in my own constituency.

General McCaffrey. I think your comments are right on the money. Most people are not foolish enough to talk about why they want methamphetamines in a 7-Eleven store near them, although there are many that actually are advancing that argument. I think that is the argument of the Lindesmith Center.

Having said that, to go directly to your point, I think Dr. Leshner and others can talk to the issue of what we know about smoked marijuana and its impact on a human being. Not just from its impact on brain function, but what we see as the consequences of extensive use of marijuana, particularly among adolescents. We do know quite a bit about it.

The other thing I would argue is that, overwhelmingly, parents and educators get the point. When you ask them in an abstract sense about marijuana, you may get one answer. But when you ask about your daughter, your son, your employees, do you personally, do you think marijuana smoking is inconsequential, the answer is quite different. Americans don't support the legalization of marijuana.

A final notion, if I may, Congresswoman. Two people that have helped form my own thinking, one of them is Dr. David Smith in the Haight-Ashbury Free Clinic in San Francisco. What a beautiful man. What an incredible organization they have put together, initially to deal with the wreckage of the drug revolution of the 1970's in San Francisco. I mean human wreckage. And now it is very well organized, and it is continuing.

If you asked Dr. David Smith with his lifelong involvement—past president of the American Society of Addictive Medicine—what about pot? Is it OK? He will answer, “are you nuts?” We get 300 kids a month off the streets of San Francisco, and their drug problem is pot.

Now, Dr. Mitch Rosenthal, Phoenix House, one of the biggest, best-organized drug treatment centers in the country, this is the

Cadillac of drug treatment, a lot of it publicly funded. Go out to his center in California, the Youth Drug Treatment Center, and those kids are in there for marijuana and alcohol. It is polydrug abuse, but primarily it is pot.

I tell people, if you have this shiny young kid, he or she is 12, 13, 14, they are playing sports, they are pleasant to be around, you admire their friends, and then a year later they are acting in a weird, irresponsible manner, their grades are dropping, they are not playing sports, they are alienated from the family, don't wonder what is going on. The problem is drugs, and that means marijuana and beer. That is what you are watching in action.

I am sympathetic to the argument, but I think if you are a teacher, if you are a mother, we have to stand against marijuana use by youngsters in particular.

Mrs. MINK. Thank you.

Mr. MICA. I thank the gentlelady.

I yield now to the gentleman from Arkansas, Mr. Hutchinson, for questions.

Mr. HUTCHINSON. I thank the chairman.

General McCaffrey, I want to go back to the questions I raised in my opening comments.

First of all, in reference to the media campaign fund that has been provided by Congress to you, are any of those funds targeted in States considering legalization of marijuana? And do you see any legal problems with having a specific message in those States urging citizens to oppose that legalization effort?

General MCCAFFREY. That media campaign, Congressman, we are enormously proud of it. We are into year two. I think we know what we are doing. We have a real professional group running it for us now. They do this for a living, Ogilvy Mather. It is no longer five of my people at 2 o'clock in the morning. These folks are buttressed by Dr. Alan Leshner who is running my evaluation component: Is this going to work? Yes or no. Show me the data. He has got Westech Corp. following it.

We have hired other outside critics, a behavioral science expert panel, people like those from the Annenberg School of Journalism. Partnership for a Drug-Free America and ONDCP have put together this program that by the end of the summer we will be in 11 foreign languages and English. We will have 102 different media strategies around this country. So whoever you are, in the drug environment in this region, we are talking to your children and the adult mentors.

It isn't much money, surprisingly. It was less than 1 percent of the Federal counterdrug budget. It was \$185 million last year. I have negotiated a 108 percent media match. But that is modest money compared to alcohol and cigarettes, \$2 billion, and \$5 billion, respectively.

I am getting to your question. I apologize for the context.

Mr. HUTCHINSON. I do have some more questions.

General MCCAFFREY. The bottom line is, we have that \$185 million targeted on confronting drug use by youngsters and their adult mentors' attitudes.

Mr. HUTCHINSON. The answer is no?

General MCCAFFREY. The answer is absolutely not. We are not going after this very important issue nor are we going to try and confront underage drinking.

Mr. HUTCHINSON. Do you see any legal problem in doing that or is that just a judgment call on your part?

General MCCAFFREY. I think it is a legal problem, but also the funds wouldn't be there to take on a political State issue to go after proposition 200 in Arizona or 215 in California.

Mr. HUTCHINSON. If there was some specific authorization by Congress to allow those funds to be used in that effort, would that overcome the legal problem you are concerned about?

General MCCAFFREY. I would think it would be harmful to this effort.

Mr. HUTCHINSON. I asked about the legal problem. I know you disagree from a policy standpoint.

General MCCAFFREY. Of course, Congress could write the law any way they wanted. I would probably argue that we are making a tremendous impact on the American people about the legalization issue without directly confronting it. We are talking about pot smoking and their kids.

Mr. HUTCHINSON. You are not using any of the campaign funds for targeted States?

General MCCAFFREY. We don't go after proposition 200 or the D.C. Campaign.

Mr. HUTCHINSON. Have you personally been into any of the States that are considering these legalization efforts to hold news conferences using the influence of your office to oppose them?

General MCCAFFREY. I have been almost everywhere in this country and have directly confronted that issue in op-eds, radio interviews, and TV. I have been on 3,000 TV interviews, 7,000 news articles, and have directly confronted these issues with some impact.

Janet Reno, of course, obviously stands with me, as does Dick Riley and Donna Shalala. The four of us are the heart and soul of this effort.

Mr. HUTCHINSON. I congratulate you on that. I would encourage you to continue doing that. I would like to see, as these issues heat up, you, Donna Shalala, the Attorney General Janet Reno, and the President of the United States going into those States and saying this is bad for the country. In my judgment that is the kind of leadership we need on these issues.

We certainly see every night on the news the power of this Presidency when it comes to media. And you and I can go into those States, we can hold news conferences, and we will not have the impact as the top official. I hope that you will be urging the President, the Vice President, and other officials to go in and really make it an initiative to make the message clear that legalization of marijuana is not the direction that we need to go.

A final question, on your media campaign, I think you said that some of your ads are specifically directed to marijuana, is that correct?

General MCCAFFREY. Absolutely. In the next generation of ads you will see starting in the fall, we have focused in on that problem. We had very little material when we started this.

Mr. HUTCHINSON. You have some of that focus on marijuana. Do you have some of that focus on crank, for example, and other drugs?

General MCCAFFREY. Yes.

Mr. HUTCHINSON. And do you have separate ads for alcohol and tobacco?

General MCCAFFREY. There are approximately 20 ads playing approximately 7,000 times that are in the matching component we have now shown and that have been vetted through the Behavioral Science Council and the Advertising Council of America. So there is an anti-alcohol youth drinking in the nonpaid component.

I would welcome the chance to provide any of you an overview of how we are developing that campaign. It is very complicated, and we think it is starting to work.

Mr. HUTCHINSON. I very well might take advantage of that. I would welcome that opportunity.

Thank you very much, Mr. Chairman.

Mr. MICA. I thank the gentleman.

I now recognize the gentleman from Maryland.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

General, let me ask you something. We have spent a lot of time here on marijuana. Let's talk about cigarettes. I think I have heard you talk about how so many of our children become involved in drugs and cigarettes. It sort of starts at cigarettes. Is that still accurate? Initially?

General MCCAFFREY. I think it is probably correct to say that cigarette smoking is almost a precursor to marijuana smoking. It is not always the case, but generally it is rare to see somebody smoking pot or, for that matter, if you go to a drug treatment center to find somebody that didn't start smoking as an adolescent.

Mr. CUMMINGS. In answering Mr. Hutchinson's question, you said that there was—I forgot your exact words, but there is a piece of your ad campaign that goes to cigarettes, is that what you said?

General MCCAFFREY. No. Some of the matching component is authorized to address the cigarette issue. What I have done is, I had a meeting with the Attorneys General of the States. They have a committee that is trying to put together their cigarette policy. I intend to support their work with our research. But there will be a different research strategy, a different way they go about that issue, since it is a legal product for those 18 and older. But we will be supporting that huge amount of money going to anti-cigarette advertising.

There is a lot of material out there. California, Florida and other States already know a lot about it.

Mr. CUMMINGS. It just seems to me that if we are going to spend this time today talking about marijuana and when we consider what you just said, that is, there seems to be a correlation in many instances between cigarette smoking and marijuana, it just seems to me that would be something that we would want to take a look at.

Again, it goes back to the hide-and-go-seek theory. The question is, what are we doing about it? I think we have made some great strides with all these settlements. So I take it that States like Maryland, are now trying to come up with strategies as to how to

use that money to prevent our children from smoking. You are saying that your office is collaborating when asked?

General McCaffrey. We are going to be supportive of these States with their programs. There is a lot of material out there they can build on.

Mr. Cummings. I don't want anybody in this room to be mistaken. I think you are doing a great job. I have felt that way all along. I think you have a very difficult job, a very challenging one.

We disagree on a few things. I think one of them may be this whole thing of methadone. When I talk to people and the former drug addicts who are recovering, living productive lives, when I talk to them about methadone, these people are averaging 12 years of nondrug use. They understand the argument that by using methadone a person can continue to be productive, and they understand all of that. But they still feel that it is like trading one drug for another drug and that the person is still addicted. I am just wondering, where are we on that? Where are you right now on that issue?

General McCaffrey. We are fortunate. We have a brilliant man, Dr. Wesley Clark, one of the smartest people I have run into in government, a lifelong psychiatrist, drug researcher, practitioner. He is Secretary Shalala's architect to relook at the methadone, LAMM and other therapeutic tools program. What we are moving toward is what evidence-based medicine has produced before, credentialed the medical drug treatment establishment to use it.

I share your uneasiness. Badly run methadone programs, the kind that Mayor Giuliani railed against in New York, are a nightmare. You shouldn't have people knock on a door that says methadone, walk through and get it. You ought to have heroin addicts—there are 810,000 of us Americans who are using heroin. Sooner or later you are going to be in despair. We need to reach out and put you in treatment, and you ought to be diagnosed.

There ought to be a triage system. We ought to use an array of tools which include psychotherapeutic communities, social interventions and, in some cases, methadone or LAMM. If you are a 35-year-old, male street prostitute, you are HIV positive, you have tuberculosis leg sores, you have been unemployed for a decade, you are living under a bridge, we have to get you into treatment. Part of that treatment program probably ought to include a methadone component.

Now, our purpose ought to be to move you along a path of treatment and to end up with you employed, back with your family and treating, not just the addiction, but treating your other diagnoses: You are malnourished; you are HIV positive.

So I think methadone and LAMM do have a place in that inventory, but it ought to be part of a package of interventions.

Mr. Cummings. Mr. Chairman, I just have one more question.

One of the things that I have seen in Baltimore, one of the reasons why numbers are so high for drug-addicted people, is that we have people who started off on heroin many years ago, and so they have been living with this thing. I know people who have been on heroin for 30 years. There was a time where I think people kind of looked at this population and said, well, you know, with crack cocaine and cocaine coming along, eventually this population would

die out. That sounds a bit morbid, but that is what they believed. Now, the word is that heroin is becoming, in certain places, attractive again, or did it ever die down? In other words, there have been some national reports, like on national news, that say heroin is cheaper and young people are more attracted to it.

What is happening there? Because I would hate to see us move into a point where we have another 30 or 40 years of someone on a substance like heroin.

General McCaffrey. The heroin addicts that have been on it for 30 years are very clever people. There are very few stupid folks who are addicted. It is such a dangerous life. The chances of living beyond 10, 15 years with a severe drug abuse problem are modest. Alcohol, heroin, methamphetamine, that is sort of the tip of the iceberg, those that can go that long.

There is more heroin abuse in our society than there was 10 years ago. These numbers are so soft, I am nervous using them. I have a number I can document, under 300,000. Another number over 500,000. The number I am using is 810,000. I think that is how many Americans are using heroin. I think there is a new population using it. There are lots of suburbanites, working class males. It is almost a new drug. Instead of 7 percent heroin, it is 70 to 90 percent heroin. Mr. Marshall will talk about it. It is like China white, stick it up your nose, ingest it, smoke it.

I am wearing a memory bracelet from a young white girl, freshman in college, dead on a respirator after 7 days smoking pure heroin and crack cocaine. This drug—a young, 21-year-old boy that I have known since he was born, Mexican black tar heroin.

The world is awash in it. We are confronting it, but Americans, we think, use 3 percent of the world's heroin. The difference is we pay \$250 to \$500 a day for it. We steal \$60,000 a year in Baltimore to get it. And you can sell it in Pakistan for \$5 a day. We have a huge problem. If we are not careful, we are going to see a resurgence in heroin addiction which is very tough to deal with.

Mr. CUMMINGS. Thank you very much.

Thank you, Mr. Chairman.

Mr. MICA. Thank you. I recognize now the gentleman from California, Mr. Ose.

Mr. OSE. Thank you, Mr. Chairman.

Good morning, General. I want to return to a subject you were talking about earlier. We had a subcommittee hearing with testimony in which there are State initiatives, referendums and the like being proposed to legalize different drugs, similar to California's where we legalized marijuana for medicinal purposes. The question I have, based on the testimony we took at this previous hearing, was that we have advertisements designed to address demand abatement, knowledge for the consumer. Are we putting those advertising efforts into these States in direct competition to the prolegalization advertising that is going on with these initiatives and referenda?

General McCaffrey. We are not targeting legislative initiatives in the State. No, absolutely not. As a matter of fact, I have been very careful—a lot of these State authorities are prohibited by law. The Lieutenant Governor of Washington, a person whom I admire enormously, was sued by a drug legalization group to confront his

efforts. He was correctly, I think, claiming that in his off-duty time he was confronting this State initiative. So we have to be a little careful about the political and legal issues.

But to get to your point, every State in this country—we are now in 102 different media markets to confront drug abuse and its consequences among adolescents and their adult mentors. Yes, we are arguing against drug abuse in America.

Mr. OSE. Let me make sure I understand, because this is the part that was confusing for me. Are you telling me that there are legal restrictions as to what the Federal Government can do to advertise the medical consequences of drug abuse?

General McCaffrey. Absolutely not.

Mr. OSE. Then what is—

General McCaffrey. Not at all.

Mr. OSE. In terms of a marketing strategy, if my competitor proposes, in a marketplace in which I am in, X and I happen to think anti-X—

General McCaffrey. Oh, medical consequences, excuse me. It is the way you are saying it.

What we can talk about is that there are consequences, medical consequences, to abusing drugs. We have no restrictions at all on accurately and scientifically portraying why we are opposed to the use, never mind the abuse, of these drugs. We are doing that.

What we wouldn't do is go head to head with a referendum in a State that tries to do something like say, let's do medical marijuana for anemia.

Mr. OSE. So the restriction deals with the specific reference to the initiative, not to—

General McCaffrey. To some political debate, right, over an initiative.

Mr. OSE. Cite for me a couple of the States—like California has adopted, Arizona has adopted.

General McCaffrey. Washington, Hawaii, possibly the District of Columbia, Colorado.

Mr. OSE. They have adopted it or it is pending?

General McCaffrey. A bunch of these have passed. The first two States are California and Arizona that have passed some form of medical legalization of certain kinds of drugs.

Mr. OSE. Are there any States where an initiative is pending for medical legalization—

General McCaffrey. I have a map that should be in your packet that shows you. I maintain a status watch by State of drug legalization initiatives, either under the guise of medical marijuana or industrial hemp. What we do about it depends upon the State and the situation. But we do have a map, you should have availability to it, and we try and track where we are on this issue.

I write Governors. I just talked to the Mayors Conference. We talk to county executives. We talk to State legislators. We have a point of contact in every State by law, NASADAD coordinators.

Mr. OSE. What I am trying to get to is, if there is someone in a State advertising a product and the product is something that is arguably harmful to the citizenry of the United States, why aren't we matching with our own marketing program, in a targeted fash-

ion, the information that would contradict or counterbalance that argument?

General McCaffrey. I want to make sure I don't talk by you. The best answer I can give you is the drug legalization people don't have a fraction of the power that we have now brought to bear on this issue.

I don't know how much money Soros—there are three or four people that have funded this whole effort. I doubt it was more than \$15 million.

So we are in the marketplace on the Internet, radio, TV, billboards, print media. We clearly are presenting a correct scientific argument on why you shouldn't use drugs. Fifty percent of that energy is at adolescents, but another 50 percent of it is aimed at adult caregivers. So we are talking to America about this problem right now.

Mr. OSE. Someone just brought me the map. Thank you for sending it up here. Recognizing on this map that we have no initiatives pending or in a large number of States, is there any logic to providing a maintenance-type effort there and transferring funds that would otherwise go in those States and targeting them at States where—for instance, we have a signature petition under way in Florida, and we have legislation introduced in five other States here, targeting those States for the purpose of either defeating very cleverly, the petition drive or the legislation by informing the public?

General McCaffrey. Let me again be explicit. We are not confronting State initiatives. We absolutely are not. If Americans want to debate whether heroin should be used as a painkiller, they are welcome to do that, to vote on it. Federal law is quite clear.

What this media campaign is doing, it is trying to affect youth attitudes to reject the abuse of drugs. Nobody has got a drug legalization initiative on the table. Nobody is stupid enough to do that. You couldn't get it through anywhere in America. You have to go an indirect route of medical pot or hemp industrialization. That is a different issue that we ought to argue on medical scientific grounds.

We are talking to America's children and their adult mentors about drug abuse, and we are swamping any drug legalization message in that effort. Nobody is out there competing now like we are. This is a 2-year, 5-year, 10-year effort to talk to America's children. It will work. It will affect youth attitudes.

Mr. OSE. I am confident of that. It seems that if whoever these individuals are who are funding this, if they take their money to Florida and target it on Florida, we ought to send the clear and unequivocal message, you go there, we're coming there, too; and we're going to make you waste your money because we're going to bring the resources of the Federal Government and its educational program to bear and put it up on the TV opposite your stuff and give people the countervailing view.

General McCaffrey. That is not what we are doing, though. We are absolutely not confronting medical drug issues head to head. We are not doing that. We are talking to young people about why these drugs are harmful to their social, intellectual, moral development.

I am normally not too hard to follow. We are not confronting political initiatives by State. The legal authority isn't there. That is not what I am doing with this money. We are going after youth attitudes and adult caregivers. But we are not shifting money around chasing George Soros's \$15 million. We are talking to America's kids, and they are using drugs in every one of these States.

This is not an urban problem, a minority problem. This is America's problem.

We are in every State in the Union doing that. We are trying to target the message by ethnic group, by age, by what drugs this group of kids see. The message is different in Boise, ID, than it is in Newark, NJ. Meth is in Boise; it isn't in Newark. If you live in Los Angeles, you will hear Spanish on the air a lot. If you are in San Francisco, we are going to be in the Chinese language on radios. So we are going after the target audience with a very powerful, correct message: Don't use drugs.

Mr. MICA. I thank the gentleman.

I would now like to recognize the gentleman from New York, Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman. I thank you for holding this hearing. I think this is a very important debate that should take place. I am happy that you are doing it.

It is also good to see you, Mr. Director, and to commend you on the outstanding job that you are doing with limited resources. I want you to know that we appreciate that as well.

My question basically, the first one, is why aren't we looking more at antagonizers? The point is that something that we could use to sort of help a person stay away from drugs when they are off, why aren't we concentrating more on that?

General McCaffrey. On what?

Mr. TOWNS. Antagonizers. In other words, like cyclazocine, a medication that would be used to sort of help a person go through the crisis.

General McCaffrey. Yes, I see.

Mr. Congressman, by the way, let me thank you for the opportunity to listen to you and talk to your faith leadership community. That was a tremendously important day to me. I benefited a lot from hearing their ideas.

You raise a good point. Dr. Leshner ought to talk to it.

We are putting a significant amount of money into research efforts dealing with new medications. Columbia University is doing some spectacular work, Johns Hopkins. There are some for-profit corporations. We will try and give the drug treatment community the same tools to deal with things like cocaine addiction. There is nothing there right now to assess.

Alan Leshner has several very promising lines of research going. We do believe that LAMM, methadone, buprenorphine and other medications should be available as an antidote to some of these drugs. I think you are quite correct. It is another tool that we ought to give our drug treatment community.

Mr. TOWNS. How do you feel about the debate that is taking place around legalization? Does it endanger the gains we have made in reducing drug use?

General MCCAFFREY. I think it is a harmful background message. On the other hand, it is a democracy. We have to address these ideas.

Four years ago, Senator Hatch and Senator Biden told me, stay away from the legalization group. Don't give legitimacy to their argument. They don't have any hold over the American people.

I think they are so clever, so devious that I welcome this hearing and the chance to confront this issue publicly.

Having said that, it is a terrible problem. Congressman Ose was quite correct. If you are a young person in California, in Arizona, you are now hearing that smoking pot has some curative power over diseases, and you wonder, if it is medicine, how can it be bad for me at age 12?

That is a conflicting message. We think it is harmful. We are going to have to deal with it, in open debate, in a democratic society.

Mr. TOWNS. Do you think that the reason we get involved in this debate so frequently is the fact that there are not enough slots available for rehabilitation in terms of a person who walked in this room right now and said, I want to be placed on a program today, I am ready to give up drugs, I am ready to give up drugs now?

I don't know what I would do, and I am a Member of the U.S. Congress and have been a Member for 17 years. I don't know what I would be able to do with that person if he or she walked in here right now and said, I want a program today. So I think that maybe the reason we keep debating this so frequently is because of the lack of slots available for rehabilitation.

General MCCAFFREY. I don't argue your point. I have to tell you, though, the U.S. Congress in 4 years has increased drug treatment funding by 26 percent. Donna Shalala now is \$3 billion plus in her prevention/treatment funding. You have given us the tools; you are moving us in the right direction in the appropriations process. We have 300,000 more treatment slots today than we had 4 years ago. We now have programs. Janet Reno is pushing to break the cycle between drugs and crime.

If you are behind bars, if you have a drug abuse problem, we have to bring effective drug treatment to bear on that population or we will never break free of it.

You did give us the money to get the drug court program up and running, so we can get on the front end of this system and put these nonviolent offenders into mandated treatment and lock them up for 3 days or 21 days to keep them on track. I think you are giving us the tools, and over time it will pay off.

Mr. TOWNS. I see my time has expired. Let me just say, I commend you on the work you are doing with the faith community. I think that is so important. I think the tie-in of the faith community with the rehabilitation is just so important, because they can play a very important role in making certain that young people in particular follow through on their treatment. Thank you so very, very much for that.

Mr. Chairman, thank you again for holding this hearing.

[The prepared statement of Hon. Edolphus Towns follows:]

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Statement of Edolphus Towns Member of Congress
Before the Subcommittee on Criminal Justice, Drug Policy
and Human Resources

Mr. Chairman, ranking member Congresswoman Patsy Mink and my colleagues from both sides of the aisle I think that today's hearing is of extreme importance to our society. Being a social worker, a former hospital administrator and now a Member of Congress I have dealt with this issue from a number of different perspectives. Drug use and control is something I take seriously and I strongly support measures to decrease drug use, but I am also aware that this is not a simple problem and requires not so simple solutions. I realize that we have those who say that this issue opens up the floodgates of substance abuse and there are those who oppose this view. I would like to begin by stating that no one thing causes substance abuse. There are a number of things involved when someone is in that type of situation.

As stated before I strongly support decreasing drug use but I think today's issue has some important points I would like to highlight. First, I think there is nothing wrong with having a dialogue about legitimate medical uses for some currently illegal substances. Helping a terminal cancer patient deal with their pain is something we can and should discuss. Helping an AIDS patient have an appetite to eat so that they can take their medication is something we can and should discuss. We should also discuss the parameters under which these substances should be monitored, used, controlled and tracked. We can and should be having these types of dialogues—educating us to make legislative decisions, which help our constituents in new ways.

Secondly, I have always been a strong supporter of innovative treatments for substance abuse, including such programs as methadone maintenance and needle exchange. We should take a look at some of the solutions we have to the problem of drug abuse. Some of these solutions are not addressing the problem. Our war on drugs, though well intentioned, needs to be a comprehensive look at the problem. Employers should insist on the treatment of employees instead of stigma and termination. Allowing workers to continue to work, take medical leave and be treated allows them to stay connected and a viable member of society.

I want to go on the record and state that I am not advocating any kind of "free for all" with drug usage. I am not saying that any and all drugs should be decriminalized. What I am saying is that substances that are shown to have scientifically proven medical uses should be looked at to see how their uses could be controlled only for medical purposes.

Mr. Chairman and ranking member Mink I applaud you for your attention to this important issue.

Mr. MICA. I now recognize our vice chairman, the gentleman from Georgia, Mr. Barr.

Mr. BARR. Thank you, Mr. Chairman.

Mr. Chairman, it has been a number of years since we have had a comprehensive hearing on the drug legalization issue; and I commend you for calling us together today.

Given the fact that much has happened in terms of research and writing on issues involving legalization of drugs, so-called medicinal use of marijuana, addiction and so forth since the last hearings on this topic, I would like to ask unanimous consent to introduce into the record a bibliography of marijuana literature, studies.

Mr. MICA. Without objection, so ordered.

Mr. BARR. The book entitled *Marijuana and Medicine*, edited by Gabriel Nahas, Kenneth Sudan, David Harvey, Stig Agurwell.

Mr. MICA. Are you asking for the entire volume?

Mr. BARR. Yes, Mr. Chairman.

Mr. MICA. Without objection, so ordered.

[NOTE.—The information referred to may be found in subcommittee files.]

Mr. BARR. We do have some additional studies that we would also like to have submitted for the record, Mr. Chairman.

Mr. MICA. Without objection, so ordered.

Mr. BARR. Thank you.

[NOTE.—The information referred to may be found in subcommittee files.]

Mr. BARR. General McCaffrey, back in the spring of this year, as you know, the Iowa Institute of Medicine published a study. While it did not argue for marijuana legalization or the ready availability of so-called medicinal use of marijuana, it did keep the issue alive and move us ever so slightly down that road.

You were quoted in the *Washington Post* as saying you, “thoroughly endorse the study” and called it, and this again is, “a significant contribution to discussing the issue from a scientific and medical viewpoint.” And that you would not, and this is not a quote, but it is attributed to you, that you would not oppose limited studies of smoked marijuana until a less harmful way of inhaling the substance’s active ingredients is found.

It is that particular notion, attributed to you, that I would like to have your reaction to. Do you, in fact, not oppose limited studies of smoked marijuana until a less harmful way of inhaling the substance’s active ingredients is found?

General MCCAFFREY. It is true. Indeed, we now have under way for about a year—Dr. Leshner can talk to it more knowledgeably than I can—we already are doing studies of smoked marijuana as medicine. We have ongoing, I think there are two more that have passed peer group review.

I think this study is a pretty good piece of work. This is the executive summary. I will make sure that the committee gets a copy of it.

These are serious people. They said up front and, Mr. Congressman, I don’t believe you were here when we responded to this in an earlier time, smoked marijuana isn’t medicine. That is what this study says. It is carcinogenic, it is a dangerous drug, it is an unknown dose rate, it is 400 plus compounds, it is 30 plus

cannabinoids. Smoked marijuana isn't medicine. That is what that study says.

It also says——

Mr. BARR. That being the case, General, why would you not oppose further studies of smoked marijuana? That being the case.

General McCAFFREY. It goes on to say that you ought to do further research on the potentially modest contributions to symptom management of cannabinoid-based research; and to avoid the problem with this carcinogenic delivery vehicle, you ought to develop a new rapid onset vehicle. So that is about 80 percent of what this says.

It also suggests, in the interim, with a population that is terminally ill, with 6 months or less to live, that something could be learned from controlled studies of a population who have not responded to any other available therapeutic measure; and we could collect data as we do under other NIH guidelines for, for example, chemotherapy drugs that haven't been yet proven to be effective.

That is really sort of a modest exception. We have funded one such study, and I think there are a couple of more we will fund.

Mr. BARR. The problem—we have talked about this before—I think it is absolutely, utterly inconsistent for the taxpayers to be funding such studies. When a company proposing to seek approval for and then market a drug seeks to do so, the government doesn't pay them to conduct the studies. They absorb the cost of that because they are the ones that want to market that product.

Here we have just the opposite. We have the Federal Government paying for it with taxpayer dollars, paying for studies that lead us in the direction of medicinal use of marijuana.

That is what I don't understand, why the Federal Government—why you or anybody else in the Federal Government should be advocating, and in fact, carrying out the use of taxpayer dollars to fund studies directed toward the possible so-called medicinal use of marijuana? If someone wants to study that, why not make them pay for it? Why should the taxpayers pay for it?

General McCAFFREY. I think largely we are going to do that.

Mr. BARR. No, you are not.

General McCAFFREY. If you will allow me to answer.

Mr. BARR. This other study cost \$900 million of taxpayer money.

General McCAFFREY. If you will allow me to answer the question, Congressman, I think the principal contribution that NIH makes is to provide medical grade marijuana for these studies. I think a lot of these sort of modest proposals are actually funded by a San Francisco-based research group. But the bottom line is, this is the same tool that is used on chemotherapy as a waiver for certain products.

I agree with you. We don't agree with smoked marijuana, and this study doesn't, either. It says smoked pot isn't medicine. But some of the cannabinoids in smoked marijuana may——

Mr. BARR. If smoked pot is not medicine, why are we using taxpayer dollars to continue to study it?

General McCAFFREY. I have provided you with the answer. You don't agree. I respect your viewpoint. That is where we are.

Mr. BARR. Let us move on to something else.

If, in fact, marijuana, the active ingredient in it, tetrahydrocannabinol, THC, is in fact a Schedule I substance, that means the drug has a high potential for abuse. Do you agree with that?

General McCAFFREY. Sure. You get stoned if you use it.

Mr. BARR. That it has no currently accepted medicinal use in treatment in the United States? I presume you agree with that.

General McCAFFREY. THC does. Marinol is available in pharmacies with a doctor's prescription right now.

Mr. BARR. Do you advocate removing that to a lesser schedule of controlled substances?

General McCAFFREY. There is a practical matter that doctors don't like using drugs under that restriction. I don't think THC competes very well with other available drugs. Certainly nobody in his right mind, according to this study, would use THC for glaucoma management. It would be bad medical practice. So THC itself has some modest potential. It has sort of passed by history. Better drugs are available.

This study is saying, how about the other 30 some odd cannabinoids? Do they have any benefit? That is really where they are urging us to go.

Mr. BARR. But you are not advocating in any way, shape or form at this time that marijuana be removed as a Schedule I controlled substance?

General McCAFFREY. Absolutely not. We are adamantly opposed to making marijuana more available to America's children and working people.

Mr. BARR. If I could, Mr. Chairman, ask one further question; and I know we need to go vote. I know we have had some discussion here today of Mr. Soros and others funding the marijuana legalization movement. Aside from what a number of us would like to see, and that is a more activist or proactivist role by our Department of Justice in rebutting and fighting these efforts, is any consideration being given to possible prosecution under perhaps the racketeering title of chapter 96 of title 18?

General McCAFFREY. Mr. Barr, in terms of the initiative by State, you mean, these medical marijuana initiatives?

Mr. BARR. Well, they are engaged in medical marijuana initiatives as well as funding other studies and activities oriented toward circumventing our drug laws.

General McCAFFREY. I don't know. That is a new one on me.

My view would be, it is a legitimate topic in a democracy to debate whether or not these psychoactive drugs should be more available in your community. If you want to propose that idea, you ought to be able to make your argument. I think it is a silly argument, it is dangerous, it is currently against the law for well-thought-out reasons, but I welcome the chance to confront that issue in open debate. I am positive American families and local leadership are not going in that route, not when the idea is aired in public as we are now doing.

Mr. BARR. You are not aware of any effort or even looking into the possibility of prosecuting that as possible racketeering?

General McCAFFREY. I don't know. There is a bit of me that says it is a possibly chilling implication on the right to free speech.

Mr. BARR. It might have a chilling effect on the drug legalization movement, which might not be bad.

General McCaffrey. I think we are going to win that. I have enormous faith in the judgment of the American people. I think this kind of argument in public, if you give them the facts, the American people will do the right thing. They are already against legalization. You can't get by the common sense of parents, pediatricians, local law enforcement. Nobody really has a grassroots movement on this effort. It is not there.

Mr. MICA. I thank the gentleman.

I would like to yield now to Mr. Souder.

Mr. SOUDER. I kind of hate to rain on the general consensus of enthusiasm for free and open debate. I am one who is not particularly happy that we are having a hearing called the pros and cons of drug legalization.

I know the chairman is very committed and has spent his whole career fighting illegal narcotics, but the plain truth of the matter is, while we live in a democracy, we do not have hearings called the pros and cons of rape, we do not have hearings called the pros and cons of child abuse, we do not have hearings called the pros and cons of racism, we do not have hearings called the pros and cons of gangs.

The thrust of this being that somehow this is a libertarian argument, that somehow somebody goes and smokes pot, that it is a victimless crime, is just not true. Those who are advocating the legalization of marijuana are responsible for blood in my district, in my neighborhood, families and my community. I don't believe they are any less guilty than those who publicly, if we hauled a bunch of rapists in here and said, hey, why do you do it—thousands of people do it, but we don't invite them up here to talk about why they favor that position. Or there are millions of Americans who are racists, but we don't openly say, explain why you're a racist to us. I don't think it is right.

I understand we are trying to be open minded here and that this hearing, with all due respect, has mostly people who share my hard-line view. But, at the same time, I don't believe that there should be views of the pros of illegal activity that is taking the lives of thousands and thousands of Americans and to give them any kind of credibility that this is a democratic debate.

I understand what General McCaffrey is arguing that, in fact, like racism at different points in American history—and in Indiana we had the Ku Klux Klan that took over the State, I don't think that was particularly helpful to democracy. I understand that some of these things, once it gets to a high level in the democracy, that there is a debate that occurs; and if we don't counter it, we have to do that. I do have an uncomfortability to this.

On a more calmed-down subject—I have just been kind of wound up since I heard about the hearing. I, too, have concerns about George Soros. Clearly he and his closest allies have funded predominantly every one of these referendums and many of the things that I have fought so hard. We are about to embark—and I appreciate all your work in many different areas and particularly in the media campaign we are doing, much of what we are doing. We are going to fight what he is doing. Have you ever attempted to just

sit down with him and talk with him and say, can you divert some of this money to trying to actually do a no use?

General McCAFFREY. I have not talked to George Soros, Peter Lewis or John Spurling. In California, for the medical rights legalization campaign, they put essentially \$1.3 million into it. Maybe I should.

I actually have enormous sympathy and resonance with what you just said. I want you to understand; don't think I've got an open mind. I am not—after 3½ years of going to drug treatment centers around America and listening to 14-year-old girls who are addicted to heroin and listening to their parents talk about it and just having come yesterday from New Orleans, from a Baptist church-based drug treatment center, I am not open minded about drug abuse in America. I think it is a crime.

It is why 1.5 million Americans got arrested. It is the reason why half that 1.8 million people are behind bars. It is more people dead each year than in the Vietnam War that shattered my generation. I think it is crazy, and I think most Americans feel the same way.

We have to put it out in public. We have to rediscover why we are opposed to a drugged, dazed life-style for our children, our fellow workers and our families.

And we are going to do that. I think it is moving in the right direction, thanks to the kind of support this Congress has given this program, and you in particular.

Mr. SOUDER. Thank you very much.

I want to reiterate, too, that in the chairman's district, we heard from a young boy and his dad who had started into marijuana and the difficulties of that family and how that led—that type of thing led a lot to the heroin epidemic in Orlando, in Arizona.

We heard from a young spouse whose husband would come home, smoke marijuana and mix it with alcohol and beat her. We have heard many moving testimonies. I hope some of those we can pull back out and put into the record with this hearing, too.

Thank you.

Mr. MICA. I thank the gentleman.

Our time has expired. We have a vote, just about 5 minutes left in that.

I think we have gotten all the questions in that we can now, General. We are going to submit additional questions to you. We are looking for some responses to some of the questions that have already been posed that you said you would respond to in writing. We thank you for your participation and cooperation and your efforts in this great mission. There being no further business at this time, we will excuse you.

We will recess for one-half hour, until approximately 12:40, so people can get a quick meal. I would like all the witnesses on the next panel to be here at 12:40, we will start promptly at that time.

The subcommittee is in recess.

[Whereupon, at 12:10 p.m., the subcommittee recessed, to reconvene at 12:40 p.m., the same day.]

Mr. MICA. I would like to call the subcommittee back to order. Since we have two panels, I would like to proceed. We will be joined by other Members shortly.

Our second panel, by way of introduction, is Dr. Alan Leshner, Director of the National Institute on Drug Abuse. Our second witness is Mr. Donnie Marshall, who is the Deputy Administrator of our Drug Enforcement Administration.

Gentleman, as you may know, this is an investigation and oversight subcommittee of Congress. We do swear in our witnesses. So if you would please stand and raise your right hands.

[Witnesses sworn.]

Mr. MICA. I would like to again welcome both of our panelists. If you have lengthy statements or additional information you would like to submit as part of the record, we would be glad to do that by unanimous consent request.

I will recognize now our first panelist, Dr. Alan Leshner, Director of the National Institute on Drug Abuse. You are recognized, sir.

STATEMENTS OF ALAN LESHNER, DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE; AND DONNIE MARSHALL, DEPUTY ADMINISTRATOR, DRUG ENFORCEMENT ADMINISTRATION

Dr. LESHNER. Thank you very much, Mr. Chairman. I want to thank you and the other committee members for inviting me to participate in this very important hearing and to speak a bit about the science of drug abuse and addiction.

My full statement, which will be submitted for the record, speaks extensively about some of the advances that we have made. I hope everyone will have an opportunity to read it.

Mr. MICA. Without objection, that will be made part of the record.

Dr. LESHNER. Thank you, sir.

Let me make some introductory comments. Scientific advances have been coming at an extraordinary rate and have virtually revolutionized our fundamental understanding of drug abuse and addiction and what to do about them.

I would say that of particular importance has been an increased understanding of the very significant effects that drug use has on the user's brain and, as a result, on his or her behavior. Many of those effects on the brain persist long after the individual stops using drugs and, therefore, their consequences can be extremely long-lasting and extremely serious.

One significant consequence, of course, is addiction, the literal compulsion to use drugs that interferes with all other aspects of life. Science has taught us that addiction is a devastating illness that results from the prolonged effects of drugs on the brain. However, I would also point out that the effects of drugs on the brain are not limited to addiction. They can result in other long-lasting behavioral abnormalities like memory deficits and psychotic-like states with some drugs.

Of course, drug abuse and addiction have tremendous negative consequences that go way beyond the health of the individual, they have consequences for the health and social well-being of the public as well. Since my written testimony highlights the very diverse array of things that science has been teaching us, I will only use one or two examples here to make an introductory point.

As one example, recent scientific advances have taught us much about the motivations or the reasons that people use drugs; and, of course, there is no single reason that people use these substances. Understanding what motivates an individual to use drugs is extremely important in designing both prevention and treatment programs. We need to know why people are using drugs if we are to influence their decision to use.

Research suggests that there are at least two distinct categories of users. One subset of people appear to use drugs simply to have a novel or sensational experience. They take them simply to produce the positive experience of modifying their mood, their perception or their emotional state.

But there is also another large group of people who take drugs for a very different reason. Although they are also trying to modify their mood, their perception, their emotional state, this group is using drugs in an attempt to help them cope with their problems. These individuals are, in effect, self-medicating. They are using drugs as if they were anti-anxiety or anti-depressant medications and, of course, over time drug use has the opposite effect. Drug use exaggerates rather than corrects underlying psychological, emotional or situational problems.

Whatever the motivation for initial drug use, though, drugs produce their effects on mood, perception and emotion by modifying brain function; and those changes in brain function have dramatic consequences both acutely in the short term and over time in the long term.

It is significant that we now know in tremendous detail, the mechanisms of action in the brain of every major drug of abuse. Among the important things we have learned, by the way, is that even though each drug has its own idiosyncratic or individual mechanism of affecting the brain, they all share some common effects and we are coming to understand these common effects as a common essence of addiction.

The implication of all of this work is that addiction actually comes about because prolonged drug use changes the brain. I would like to use just one poster to demonstrate one of these important differences in brain function caused by prolonged drug use, but I would like you to know that we have identified similar kinds of changes for many other drugs as well.

What you are seeing here on my right is the brain's ability to use a critical neurochemical called dopamine. The ability to use dopamine is critical to normal cognitive functioning and to the normal experience of pleasure, among other things, so interfering with dopamine function has significant negative behavioral consequences.

What this poster is showing you is the very long-lasting effects on the brain that methamphetamine in particular can have. So the scan on the left is that of a nondrug user. The next one is of a chronic methamphetamine user who was drug free for about 3 years when this image was taken. So this is a persistent effect of methamphetamine, basically to destroy the brain's ability to use this chemical substance.

The third scan is of a chronic methcathinone addict who was also drug free for about 3 years, and the last image is of the brain of

an individual newly diagnosed with Parkinson's disease. What you are seeing here is that, when compared with the control on the left, there is a significant loss in the brain's ability to transport dopamine back into brain cells.

As I just mentioned, dopamine function is critical to emotional regulation. It is involved in the normal experience of pleasure and, of course, is involved in controlling motor function. Therefore, this long-lasting impairment in dopamine function might account for some of the very bizarre behavioral dysfunctions that persist for so long after long-term methamphetamine use.

We believe that this kind of scientific evidence emphasizes dramatically the significant dangers in drug use; and, again, significant brain changes have been observed after individuals use any drug—marijuana, cocaine, heroin, amphetamines, nicotine; and no one is immune from the effects of drugs on the brain and the body.

Studies such as these have taught us that drug use is an equal opportunity destroyer. That is why we say that there is no such thing as recreational drug use. Drug use is never good for you. It is not like playing ping-pong, and it is not like playing tennis. It is therefore as a scientist and an official concerned with the public health that I applaud your holding this hearing and your highlighting these kinds of health consequences of drug use. I thank you for the opportunity to participate.

Mr. MICA. Thank you for your testimony.

[The prepared statement of Dr. Leshner follows:]

**Hearing before the
House Committee on Government Reform
Subcommittee on Criminal Justice, Drug Policy and Human Resources**

“Drug Legalization”

Alan I. Leshner, Ph.D.
Director
National Institute on Drug Abuse
National Institutes of Health
Department of Health and Human Services

June 16, 1999
Room 2154
Rayburn House Office Building

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Statement by
 Alan I. Leshner, Ph.D.
 Director, National Institute on Drug Abuse

Thank you for inviting me to participate in this hearing. What I would like to do this morning is illustrate through the use of some recent research findings what science has come to teach us about one of our Nation's most serious public health problems--drug abuse and addiction. I would like to point out at the onset that the scientific advancements in the drug abuse and addiction field have been coming at an extraordinary rate and are truly revolutionizing how we, both as a field of science, and as a society, approach the complex problem of addiction.

We have learned a great deal about what drugs do to the brain in recent years. In fact, we now know more about abused drugs and the brain than is known about almost any other aspect of brain function. By building on this advanced understanding of addiction and by utilizing emerging state-of-the-art technologies we can now actually see how brain mechanisms work both under normal conditions and when affected by drugs of abuse. These tools have allowed us to cast away the old popular belief held by many that addiction is just a lot of drug use. It is not that simple. In fact, addiction is a chronic, and for many people, reoccurring disease characterized by compulsive drug seeking and use that results from the prolonged effects of drugs on the brain. These brain changes are essentially what makes addiction a brain disease. This is a conclusion reached by not just the researchers that my Institute supports, but by a number of other highly credible research-oriented sources, such as the National Academy of Sciences Institute of Medicine and the American Medical Association, among others. And as you yourselves

will see shortly, from the brain image posters that I brought, the addicted brain is in fact different from the non-addicted brain.

What science has come to show as the “changed” brain of the addict is in fact what we have come to believe causes the compulsion to use drugs. Once a person becomes addicted, they become preoccupied with their quest for seeking and using drugs. The negative consequences that may result from taking the drugs are no longer an important issue for them. It is the behaviors that accompany this compulsion that are the elements responsible for the enormous health and social problems that drug addiction brings in its wake. Drug abuse and addiction have tremendous negative implications for not only the health of the individual, but for the health of the public as well. Drug use, directly or indirectly, is a major factor in crime and delinquency, work productivity, and is a vector for the spread of HIV/AIDS and other serious infectious diseases. With the most recent estimate of the economic burden for drug abuse estimated to exceed \$109 billion, it is more imperative than ever that we rely on research to develop effective prevention and treatment programs that will reduce the burden of this disease. Science should also be the foundation for any health and social policy decisions that are made regarding drug use.

Science has also given us a more insightful understanding of why people take drugs.

People use drugs for a variety of reasons. Some people take drugs simply to have a novel or sensational experience. They take them for the experience of modifying their mood, their perceptions, or their emotional state. But there is also another group of people who take drugs for a different reason. Although they may take drugs to modify their mood or their emotional state, they seem to be using drugs to help them cope with their problems. These individuals are, in effect, self-medicating. Whatever their initial motivation, people

basically take drugs because drugs make them feel good or better immediately, and this occurs because drugs essentially change the way the brain functions. This is why we say that people take drugs because they like what they do to their brains.

However, the pleasurable effects do not last long. As the drug use continues, tolerance to the drug often develops, meaning more frequent drug use is required for the brain to register the same level of pleasure experienced during initial use. This often leads to even more prolonged drug use. And as I mentioned earlier, prolonged drug use has been found to cause pervasive changes in brain function.

This seems to be the case for almost every drug of abuse, including alcohol, nicotine, marijuana, cocaine, heroin, and methamphetamine, a problem that has reached epidemic proportions in many regions of the country. All of these drugs have been found to produce noticeable changes in the brain. Regardless of the idiosyncratic effects that each drug causes, all of these drugs have been found to elevate levels of the neurotransmitter dopamine in the brain pathways that control reward and pleasure. It is this change in dopamine that we have come to believe is a fundamental characteristic of all addictions. Of course this is not to say that an individual has to abuse drugs for an entire lifetime for drugs to be harmful to their brains and their bodies. Acute drug use can also modify brain function in critical ways. The effects of cocaine, for example, appear immediately after a single dose. It alters the brain so the individual feels euphoric and mentally alert, especially to the sensation of sight, sound and touch. Cocaine use can also constrict blood vessels, and increase heart rate and blood pressure. Even short-term marijuana use, for example, can affect the brain, by modifying learning abilities, memory, emotional state, perception, and motor coordination. Prolonged marijuana use has been found to alter memory and learning processes, the brain, the lungs, and the immune system. And of course chronic use can lead to addiction.

I would like to use two posters to illustrate how the brain of an addict differs from those of a non-addict. Even more importantly, these images provide two dramatic examples of the long-lasting effects that drugs can have on the brain. These images are particularly alarming given that both of these drugs, methamphetamine and MDMA or “Ecstasy” are being used increasingly by young adults at levels that have been found to be toxic in animals. These are the first direct images showing the effects of these drugs on the brains of humans and the effects are the same as they were in animals.

Figure 1 shows images of two human brains. The one on top belongs to an individual who has never used Ecstasy. The bottom images show the brain of an individual who had used Ecstasy heavily for an extended period, but was abstinent from drugs for at least three weeks prior to the study. Clearly the brain of the Ecstasy user on the bottom has been significantly altered. The specific parameter being measured is the brain’s ability to bind the chemical neurotransmitter serotonin. Serotonin is critical to normal experiences of mood, emotion, pain, and a wide variety of other behaviors. On the figure, brighter colors reflect greater serotonin transporter binding; dull colors mean less binding capacity. This figure shows a decrease in the Ecstasy user’s ability to remove this important neurotransmitter from the intracellular space, thereby amplifying its effects within the brain. This decrease lasts at least three weeks after the individual has stopped using Ecstasy. Given serotonin’s critical role in many behavioral characteristics, one can speculate that this abnormality of the serotonin system might be responsible for some of Ecstasy’s long-lasting behavioral effects.

Figure 2 also demonstrates the long-lasting effects that drugs can have on the brain. Here you can see dopamine transporter binding in four different adults. Brighter colors reflect greater dopamine binding capacity. The scan on the left is that of a non-drug user, the next is of a chronic methamphetamine user who was drug free for about three years when this image was taken, followed by a chronic methcathinone abuser who was also drug free for about three years. The last image is of the brain of an individual newly diagnosed with Parkinson's Disease, a disease known to deplete dopamine in certain areas of the brain. When compared with the control on the left, one can see the significant loss in the brain's ability to transport dopamine back into brain cells. Dopamine function is critical to emotional regulation, is involved in the normal experience of pleasure and is involved in controlling an individual's motor function. Thus, this long-lasting impairment in dopamine function might account for some of the behavioral dysfunctions that persist after long-term methamphetamine use.

It is this type of scientific data that should be alarming to every citizen of this Nation. Taking drugs is not something anyone should take lightly. Even occasional drug use can be dangerous and there is no way to predict who may suffer drastic consequences as a result of experimenting with drugs. Some people are just more sensitive to the effects of drugs than others. Generally speaking, no one starts out in life saying they want to grow up to be a drug addict. And I doubt that anyone thinks that their initial decision to use drugs may be something that effects them the rest of their lives. They don't take into account that their occasional drug use may be having an effect on their brain. And I don't think anybody wants to intentionally give themselves a brain disease. These are some of

the reasons that as a scientist and a public health official, it is my responsibility to inform people about what drugs can do to the brain. It is also my responsibility to inform policy makers about the science of addiction so they are able to make policy decisions that are in the public's best interests.

Thank you for the opportunity to testify at this hearing.

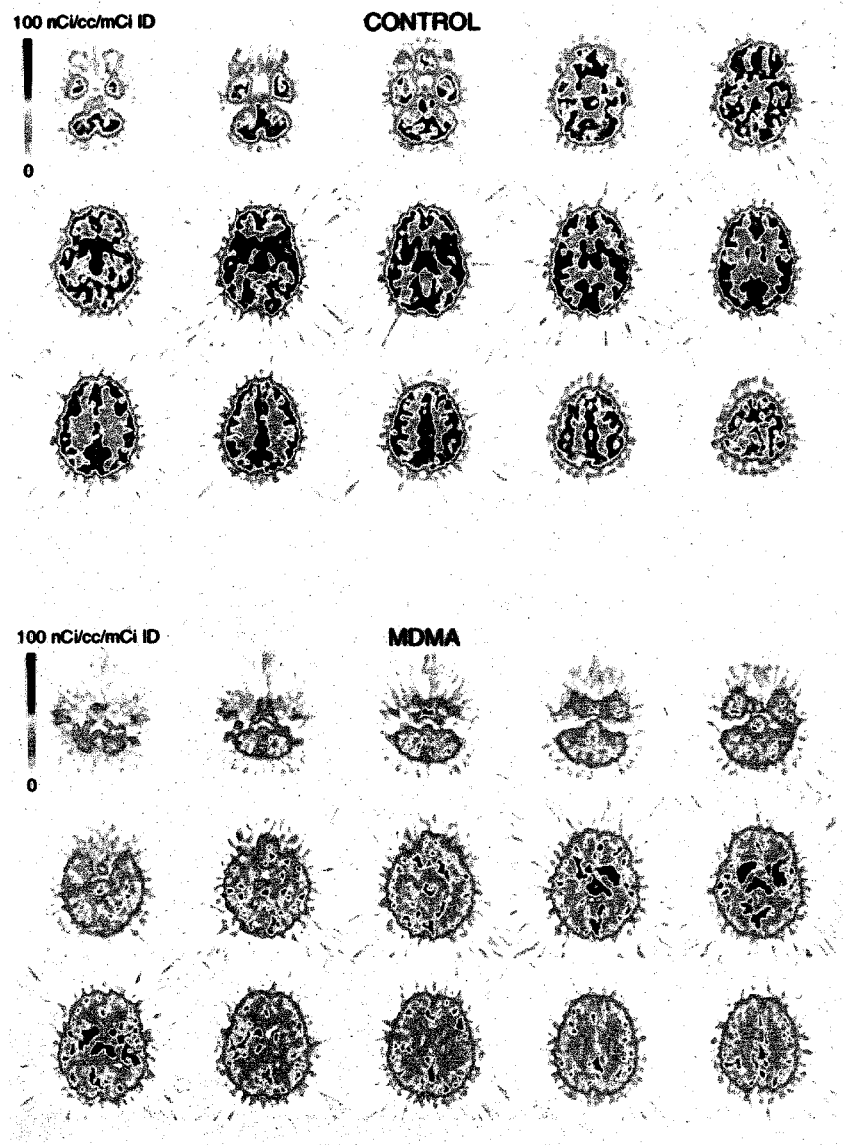


Figure 1

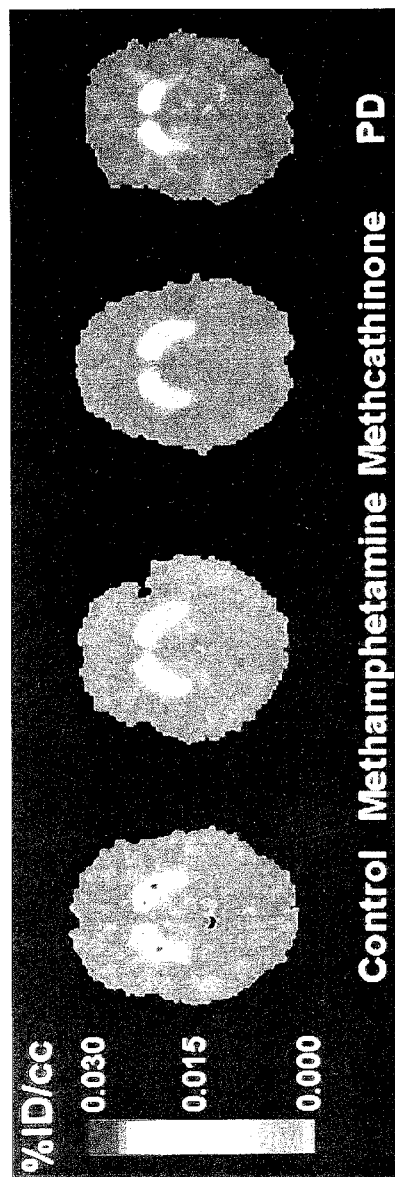


Figure 2

Mr. MICA. We will withhold questions until we have heard from our second panelist, who is Mr. Donnie Marshall, Deputy Administrator of our Drug Enforcement Agency.

Welcome, and you are recognized, sir.

Mr. MARSHALL. Mr. Chairman, members of the subcommittee, thank you very much. It is an honor to appear here.

I have submitted a written statement that I would like to have placed in the record.

Mr. MICA. Without objection, so ordered.

Mr. MARSHALL. I would also like to say, Mr. Chairman, first of all, that I want to express my thanks to the subcommittee, the chairman and the members for your support of drug law enforcement, the DEA in particular.

I would like to recognize the presence of members of the law enforcement community here today—the National Troopers Coalition, the National Narcotic Officers Association Coalition and members of several State narcotic officers associations—and recognize their tireless work in the efforts to protect our citizens and particularly our youth from drugs and drug trafficking.

What I would like to do today—I am not a scientist. It is an honor to appear here with a distinguished scientist such as Alan Leshner. I would like to talk to you really as a professional law enforcement person but also as a parent and a community volunteer. What I would like to discuss is what I think would happen—based on my best professional opinion, what would happen if drugs were legalized and then outline why I think a policy of drug enforcement and prevention does work.

I know that a lot of the current debate has really been over the legalization of marijuana, of medical marijuana. I suspect, though, that legalization of medical marijuana is really the first tactical maneuver in a strategy that some hope will result ultimately in the legalization of marijuana and all drugs.

I think the practical outcome of legalizing any drug would simply be to increase the amount of drugs available and, in turn, increase drug use, abuse and all of the crime and violence that go along with that. I really can't imagine anybody arguing that legalizing drugs would reduce the amount of drug abuse that we already have.

Although drug abuse is down from its high mark in the 1970's, we still have entirely too much drug abuse and too much drug availability in this country. In 1962, there were only 4 million Americans who had ever tried an illegal drug. In 1997, roughly 77 million Americans have tried drugs.

This escalation I think, along with the permissiveness and the greater availability of drugs—I think that the escalation really drives a central point that I would like to make and that is that supply, in my best professional judgment, drives demand.

What legalization could mean for drug consumption in the United States really can be seen in the marijuana liberalization experiment in Holland, that has already been referred to, that began in 1976. Holland has now acquired a reputation as the drug capital of Europe.

Another illustration I think of supply driving demand is the recent surge in heroin abuse in this country. Starting in the early

1990's, traffickers from Colombia realized that there were tremendous profits to be made in heroin trafficking; and they began to produce sizable amounts of high-purity heroin. By developing these high-purity heroin levels, they attracted many new potential users that might not have otherwise been inclined to use the needle because they can use this high-purity heroin through an inhalant method of usage.

In order to develop a consumer market for this high-purity heroin, they used aggressive marketing strategies. They began to use brand names. They began to market their heroin with cocaine. They began actually to require cocaine traffickers to move heroin as a condition of accepting their cocaine product.

These examples really are not just my feelings from a law enforcement perspective. There are others who support this line of reasoning, such as Dr. Herbert Kleber, who is one of the leading authorities on drug addiction.

In a 1994 article in the New England Journal of Medicine, Dr. Kleber presented clinical data to support the premise that drug use would increase with legalization. He stated in this article, and I quote: Cocaine is a much more addictive drug than alcohol. If cocaine were legally available as alcohol and nicotine are now, the number of abusers might be nine times higher than the current number.

I believe that there is also a close relationship between drugs and crime, and this relationship can be borne out by statistics. Invariably, a majority of the individuals who were arrested for violent crime in recent years have tested positive for the presence of drugs at the time of their arrest.

Further, there is a misconception that most drug-related crimes involve people who are looking for money to buy drugs. Most drug-related crimes are actually committed by people who are under the influence of mind-altering drugs; and with increased availability of drugs, more people would be abusing drugs. Therefore, I believe more people would be committing those crimes, and I think the crime rate would actually go up rather than down.

To illustrate this, I would show a 1994 study by the Bureau of Justice statistics that compared Federal and State prison inmates in 1991. This study found that 18 percent of the Federal inmates who were incarcerated for homicide had committed that offense under the influence of drugs, whereas only 2.7 percent of those people had committed the offense to obtain money for drugs.

There has been example after example that illustrate the effects of increased availability of drugs. We have heard a couple of those examples today, particularly Baltimore. We could debate the causes and the solutions to the Baltimore example, but we really can't debate the tragedy that is involved with the Baltimore example.

In New York, in response to the drug and crime problem, a strong law enforcement response was mounted. This has been effective in addressing the upward trend of violent crime. In New York, the homicide rate in 1990 had risen to the highest level ever, 2,262. By 1998, as a result of the law enforcement response, that homicide rate dropped to 663, a 70 percent reduction in just 8 years. What that really means in human terms is had the murder rate stayed at the 1990 level, by 1998 there would have been 1,629

more people dead than had actually died. I believe it is fair to say that those 1,629 human beings owe their lives to the law enforcement response in New York.

Proponents of drug legalization often point to the liberalization experiments in Europe to show that other nations have successfully controlled drugs by providing drugs and areas where they can be legally used. My question would be that if those experiments have been so successful, why have there been 184 cities in 30 European countries who adopted the European Cities Against Drugs resolution, commonly known as the Stockholm resolution, which rejects the liberalization approach?

If you really want to discover, though, what legalization might mean to society, I suggest you talk to a clergyman, a junior high school teacher, a high school coach, a scout leader or a parent. I would ask you, and I bet I know the answer, how many parents or teachers have ever come into your office to say, Congressman, the thing our kids really need is easier availability to illegal drugs? I bet you have never had a parent come in and say that.

Drug addiction and its tragedy, affect entire families. It is a tragedy for everybody involved. It wouldn't matter one bit to those families and those victims whether those drugs were legal or illegal. The human misery would be just the same. The only difference is there would be more of it.

Finally, the point I would like to make, that drug legalization would be a law enforcement nightmare. I bet there are very few people in the country who would propose making drugs legal to a 12-year-old child. That reluctance points up a major flaw in the legalization proposal. Drugs will always be denied to some sector of our population. So there will always be some form of black market and some need for drug enforcement and prevention programs.

I know that there are those who would make the case that drug addiction hurts no one but the user, but if that lie really becomes part of the conventional wisdom, there will be a lot of pressure to legalize all drug use. If that were done, I believe we could reverse that tide only when we see the harmful effects over the years of widespread drug abuse. By then, I believe it would be too late to reverse that tide. I believe that this is no time to undermine our efforts to stem drug abuse.

I would offer that from 1979 to 1994 the number of drug users in America dropped almost by half. I believe that two things significantly contributed to that drop—a strong program of public education and a strict program of law enforcement. Drug laws and prevention programs can work if we have the national resolve to enforce them.

As a father and someone who has had a lot of involvement with kids and Boy Scouts and Little League, and as a 30-year civil servant in drug enforcement, I can tell you that there are a lot of young people out there that are looking for help. Sometimes helping those people means saying no, it means setting limits, and it means having the courage to back that up.

I would like to tell you about one of those young people who I have helped over the course of my career. During the early 1970's when I was a young drug agent in Austin, TX, we arrested a young man, I will call him John, on drug charges. John had a young preg-

nant wife at the time. They were devastated by his arrest. But after he had served his sentence, he and his wife came to my office in Austin looking for me. I was a little bit apprehensive about meeting with them at first, but I went ahead and met with them.

They told me that they had come in so that I could see their new baby who had been born while John was in jail. They also outlined a second reason. Both of these people agreed that their experience with drugs and John's arrest had been one of the most horrible experiences that had ever happened to them. But that arrest was probably what saved them.

John explained to me that he had started using drugs because they were readily available in Austin, TX, in the early 1970's and because he had seen widespread drug use among his peers. He quit playing sports. He ignored warnings from his parents, from his teachers. Finally, he dropped out of school altogether.

I had no idea that night when I arrested him what the long-term impact would be and that I would have a positive influence on that young man's life. I suspect that this young man was a pretty typical person, one who used drugs because they were readily available and because they were socially acceptable.

I believe that as a society, we have to help our young people and we have to keep them from taking that first step into the world of drugs that will ruin their careers, destroy marriages and leave them in a cycle of drug dependency. If we don't have the courage to say no to drug abuse, I believe we will find that drugs will ruin millions of lives and ultimately could destroy the society that we have built over the last 200 years.

Drug-abuse-related crime, personal degeneration and social decay, all of that goes with it, those things are not inevitable. They are not inevitable. Too many people in this country, I believe, seem resigned to this growing rate of drug abuse; and too many people seem ready to give up. But our experience with drugs shows that strong law enforcement and prevention program policies can and do work if we have the courage, the strength and the persistence to stay the course.

At DEA, our mission, quite simply, is to disrupt the major trafficking organizations and to fight drug trafficking in order to make drug abuse expensive, unpleasant, risky and disreputable. If the drug users themselves and the traffickers aren't worried about their own health, the health of others or the welfare of people who are affected by their products, then they should at least have to worry about the likelihood of getting caught and going to prison.

Mr. Chairman, thank you very much for the opportunity to appear. I will be happy to try to answer any questions you or your committee may have.

Mr. MICA. Thank you for your testimony.

[The prepared statement of Mr. Marshall follows:]

Remarks by

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Deputy Administrator
Drug Enforcement Administration
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before the

House Government Reform and Oversight Committee's
Subcommittee on Criminal Justice, Drug Policy and Human
Resources

regarding

"The Drug Legalization Movement in America"



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Donnie Marshall
Deputy Administrator
Drug Enforcement Administration
Subcommittee on Criminal Justice, Drug Policy and Human Resources
U.S. House of Representatives
June 16, 1999

Mr. Chairman and Members of the Subcommittee, I appreciate the opportunity to appear before you today on the issue of drug legalization, decriminalization and harm reduction.

I am not a scientist, a doctor, a lawyer, or an economist. So I'll do my best to leave the scientific, the medical, the legal and the economic issues to others. At the Drug Enforcement Administration, our mission is not to enact laws, but to enforce them. Based on our experience in enforcing drug laws, I can provide you with information and with our best judgment about policy outcomes that may help put into context the various arguments in this debate.

I would like to discuss what I believe would happen if drugs were legalized. I realize that much of the current debate has been over the legalization of so-called medical marijuana. But I suspect that medical marijuana is merely the first tactical maneuver in an overall strategy that some hope will lead to the eventual legalization of all drugs.

Whether all drugs are eventually legalized or not, the practical outcome of legalizing even one, like marijuana, is to increase the amount of usage among all drugs. It's been said that you can't put the genie back in the bottle or the toothpaste back in the tube. I think those are apt metaphors for what will happen if America goes down the path of legalization. Once America gives into a drug culture, and all the social decay that comes with such a culture, it would be very hard to restore a decent civic culture without a cost to America's civil liberties that would be prohibitively high.

There is a huge amount of research about drugs and their effect on society, here and abroad. I'll let others better acquainted with all of the scholarly literature discuss that research. What I will do is suggest four probable outcomes of legalization and then make a case why a policy of drug enforcement works.

Legalization would boost drug use

The first outcome of legalization would be to have a lot more drugs around, and, in turn, a lot more drug abuse. I can't imagine anyone arguing that legalizing drugs would reduce the amount of drug abuse we already have. Although drug use is down from its high mark in the late 1970s, America still has entirely too many people who are on drugs.

In 1962, for example, only four million Americans had ever tried a drug in their entire lifetime. In 1997, the latest year for which we have figures, 77 million

Americans had tried drugs. Roughly half of all high school seniors have tried drugs by the time they graduate.

The result of having a lot of drugs around and available is more and more consumption. To put it another way, supply to some degree drives demand. That is an outcome that has been apparent from the early days of drug enforcement.

What legalization could mean for drug consumption in the United States can be seen in the drug liberalization experiment in Holland. In 1976, Holland decided to liberalize its laws regarding marijuana. Since then, Holland has acquired a reputation as the drug capital of Europe. For example, a majority of the synthetic drugs, such as Ecstasy (MDMA) and methamphetamine, now used in the United Kingdom are produced in Holland.

The effect of supply on demand can also be seen even in countries that take a tougher line on drug abuse. An example is the recent surge in heroin use in the United States. In the early 1990s, cocaine traffickers from Colombia discovered that there was a lot more profit with a lot less work in selling heroin. Several years ago, they began to send heroin from South America to the United States.

To make as much money as possible, they realized they needed not only to respond to a market, but also to create a market. They devised an aggressive marketing campaign which included the use of brand names and the distribution of free samples of heroin to users who bought their cocaine. In many cases, they induced distributors to move quantities of heroin to stimulate market growth. The

traffickers greatly increased purity levels, allowing many potential addicts who might be squeamish about using needles to inhale the heroin rather than injecting it. The result has been a huge increase in the number of people trying heroin for the first time, five times as many in 1997 as just four years before.

I don't mean to imply that demand is not a critical factor in the equation. But any informed drug policy should take into consideration that supply has a great influence on demand. In 1997, American companies spent \$73 billion advertising their products and services. These advertisers certainly must have a well-documented reason to believe that consumers are susceptible to the power of suggestion, or they wouldn't be spending all that money. The market for drugs is no different. International drug traffickers are spending enormous amounts of money to make sure that drugs are available to every American kid in a school yard.

Dr. Herbert Kleber, a professor of psychiatry at Columbia University College of Physicians and Surgeons, and one of the nation's leading authorities on addiction, stated in a 1994 article in the *New England Journal of Medicine* that clinical data support the premise that drug use would increase with legalization. He said:

"There are over 50 million nicotine addicts, 18 million alcoholics or problem drinkers, and fewer than 2 million cocaine addicts in the United States. Cocaine is a much more addictive drug than alcohol. If cocaine were legally available, as alcohol and nicotine are now, the number of cocaine abusers would probably rise to a point somewhere between the number of users of the other two agents, perhaps 20 to 25 million...the number of compulsive users might be nine times higher than the current

number. When drugs have been widely available -- as...cocaine was at the turn of the century -- both use and addiction have risen."

I can't imagine the impact on this society if that many people were abusers of cocaine. From what we know about the connection between drugs and crime, America would certainly have to devote an enormous amount of its financial resources to law enforcement.

Legalization would contribute to a rise in crime.

The second outcome of legalization would be more crime, especially more violent crime. There's a close relationship between drugs and crime. This relationship is borne out by the statistics. Every year, the Justice Department compiles a survey of people arrested in a number of American cities to determine how many of them tested positive for drugs at the time of their arrest. In 1998, the survey found, for example, that 74 percent of those arrested in Atlanta for a violent crime tested positive for drugs. In Miami, 49 percent; in Oklahoma City, 60 percent.

There's a misconception that most drug-related crimes involve people who are looking for money to buy drugs. The fact is that the most drug-related crimes are committed by people under the influence of mind-altering drugs. A 1994 study by the Bureau of Justice Statistics compared Federal and state prison inmates in 1991. It found that 18 percent of the Federal inmates incarcerated for homicide had committed homicide under the influence of drugs, whereas 2.7 percent of these individuals had committed the offense to obtain money to buy drugs. The

same disparities showed up for state inmates: almost 28 percent committed homicide under the influence versus 5.3 percent to obtain the money to buy drugs.

Those who propose legalization argue that it would cut down on the number of drug-related crimes because addicts would no longer need to rob people to buy their drugs from illicit sources. But even supposing that argument is true, which I don't think that it is, the fact is that so many more people would be abusing drugs, and committing crimes under the influence of drugs, that the crime rate would surely go up rather than down.

It's clear that drugs often cause people to do things they wouldn't do if they were drug-free. Too many drug users lose the kind of self-control and common sense that keeps them in bounds. In 1998, in the small community of Albion, Illinois, two young men went on a widely reported, one-week, non-stop binge on methamphetamine. At the end of it, they started a killing rampage that left five people dead. One was a Mennonite farmer. They shot him as he was working in his fields. Another was a mother of four. They hijacked her car and killed her.

The crime resulting from drug abuse has had an intolerable effect on American society. To me, the situation is well illustrated by what has happened in Baltimore during the last 50 years. In 1950, Baltimore had just under a million residents. Yet there were only 300 heroin addicts in the entire city. That's fewer than one out of every 3,000 residents. For those 300 people and their families, heroin was a big problem. But it had little effect on the day-to-day pattern of life for the vast majority of the residents of Baltimore.

Today, Baltimore has 675,000 residents, roughly 70 percent of the population it had in 1950. But it has 130 times the number of heroin addicts. One out of every 17 people in Baltimore is a heroin addict. Almost 39,000 people. For the rest of the city's residents, it's virtually impossible to avoid being affected in some way by the misery, the crime and the violence that drug abuse has brought to Baltimore.

People who once might have sat out on their front stoops on a hot summer night are now reluctant to venture outdoors for fear of drug-related violence. Drug abuse has made it a matter of considerable risk to walk down the block to the corner grocery store, to attend evening services at church, or to gather in the school playground.

New York City offers a dramatic example of what effective law enforcement can do to stem violent crime. City leaders increased the police department by 30 percent, adding 8,000 officers. Arrests for all crimes, including drug dealing, drug gang activity and quality of life violations which had been tolerated for many years, increased by 50 percent. The capacity of New York prisons was also increased.

The results of these actions were dramatic. In 1990, there were 2,262 homicides in New York City. By 1998, the number of homicides had dropped to 663. That's a 70 percent reduction in just eight years. Had the murder rate stayed the same in 1998 as it was in 1990, 1,629 more people would have been killed in

New York City. I believe it is fair to say that those 1629 human beings owe their lives to this effective response by law enforcement.

Legalization would have consequences for society

The third outcome of legalization would be a far different social environment. The social cost of drug abuse is not found solely in the amount of crime it causes. Drugs cause an enormous amount of accidents, domestic violence, illness, and lost opportunities for many who might have led happy, productive lives.

Drug abuse takes a terrible toll on the health and welfare of a lot of American families. In 1996, for example, there were almost 15,000 drug-induced deaths in the United States, and a half-million emergency room episodes related to drugs. The Centers for Disease Control and Prevention has estimated that 36 percent of new HIV cases are directly or indirectly linked to injecting drug users.

Increasing drug use has had a major impact on the workplace. According to estimates in the 1997 National Household Survey, a study conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), 6.7 million full-time workers and 1.6 million part-time workers are current users of illegal drugs.

Employees who test positive for drug use consume almost twice the medical benefits as nonusers, are absent from work 50 percent more often, and make more

than twice as many workers' compensation claims. Drug use also presents an enormous safety problem in the workplace.

This is particularly true in the transportation sector. Marijuana, for example, impairs the ability of drivers to maintain concentration and show good judgment on the road. A study released by the National Institute on Drug Abuse surveyed 6,000 teenage drivers. It studied those who drove more than six times a month after using marijuana. The study found that they were about two-and-a-half times more likely to be involved in a traffic accident than those who didn't smoke marijuana before driving.

The problem is compounded when drivers have the additional responsibility for the safety of many lives. In Illinois, for example, drug tests were administered to current and prospective school bus drivers between 1995 and 1996. Two hundred tested positive for marijuana, cocaine and other drugs. In January 1987, a Conrail engineer drove his locomotive in front of an Amtrak passenger train, killing 16 people and injuring 170. It was later determined that just 18 minutes before the crash, both he and his brakeman had been smoking marijuana.

In addition to these public safety risks and the human misery costs to drug users and their families associated with drug abuse, the Office of National Drug Control Policy has put a financial price tag on this social ill. According to the 1999 National Drug Control Strategy, illegal drugs cost society about \$110 billion every year.

Proponents of legalization point to several liberalization experiments in Europe -- for example, the one in Holland that I have already mentioned. The experiment in Holland is now 23 years old, so it provides a good illustration of what liberalizing our drug laws portends.

The head of Holland's best known drug abuse rehabilitation center has described what the new drug culture has created. The strong form of marijuana that most of the young people smoke, he says, produces "a chronically passive individual....someone who is lazy, who doesn't want to take initiatives, doesn't want to be active -- the kid who'd prefer to lie in bed with a joint in the morning rather than getting up and doing something."

England's experience with widely available heroin shows that use and addiction increase. In a policy far more liberal than America's, Great Britain allowed doctors to prescribe heroin to addicts. There was an explosion of heroin use. According to James Q. Wilson, in 1960, there were 68 heroin addicts registered with the British Government. Today, there are roughly 31,000.

Liberalization in Switzerland has had much the same results. This small nation became a magnet for drug users the world over. In 1987, Zurich permitted drug use and sales in a part of the city called Platzspitz, dubbed "Needle Park." By 1992, the number of regular drug users at the park had reportedly swelled from a few hundred in 1982 to 20,000 by 1992. The experiment has since been terminated.

In April, 1994, a number of European cities signed a resolution titled "European Cities Against Drugs," commonly known as the Stockholm resolution. Currently the signatories include 184 cities or municipalities in 30 different countries in Europe. As the resolution stated: "...the answer does not lie in making harmful drugs more accessible, cheaper and socially acceptable. Attempts to do this have not proved successful. We believe that legalizing drugs will, in the long term, increase our problems. By making them legal, society will signal that it has resigned to the acceptance of drug abuse." I couldn't say it any better than that. After seeing the results of liberalization up close, these European cities clearly believe that liberalization is a bad idea.

You do not have to visit Amsterdam or Zurich or London to witness the effects of drug abuse. If you really want to discover what legalization might mean for society, talk to a local clergyman or an eighth grade teacher, or a high school coach, or a scout leader or a parent. How many teachers do you know who come and visit your offices and say, Congressman, the thing that our kids need more than anything else is greater availability to drugs. How many parents have you ever known to say, "I sure wish my child could find illegal drugs more easily than he can now."

Or talk to a local cop on the beat. Night after night, they deal with drug-induced domestic violence situations. They respond to a 911 call and there is a fight, and the people are high on pot or speed, or the husband or father is a heroin addict, and you can't wake him up or he's overdosed in the family bedroom. That's where you see the real effects of drugs.

Anyone who has ever worked undercover in drug enforcement has witnessed young children, 12- and 14-year old girls, putting needles into their arms, shooting up heroin or speed. To feed their habit, the kids start stealing from their parents and their brothers and sisters, stealing and pawning the watch that's been handed down from their grandmother to buy a bag of dope. Drug addiction is a family affair. It's a tragedy for everyone involved. And it wouldn't matter a bit to these families if the drugs were legal. The human misery would be the same. There would just be more of it.

Legalization would present a law enforcement nightmare

The fourth outcome of legalization would be a law enforcement nightmare. I suspect few people would want to make drugs available to 12-year old children. That reluctance points to a major flaw in the legalization proposal. Drugs will always be denied to some sector of the population, so there will always be some form of black market and a need for drug enforcement.

Consider some of the questions that legalization raises: What drugs will be legalized? Will it be limited to marijuana? What is a safe dosage of methamphetamine or of crack cocaine? If the principle is advanced that drug abuse is a victimless crime, why limit drug use to marijuana?

I know that there are those who will make the case that drug addiction hurts no one but the user. If that becomes falsely part of the conventional wisdom, there will certainly be pressure to legalize all drug use. Only when people come to

realize how profoundly all of us are affected by widespread drug abuse will there be pressure to put the genie back in the bottle. By then, it may be too late.

But deciding what drugs to legalize will only be part of the problem. Who will be able to buy drugs legally? Only those over 18 or 21? If so, you can bet that many young people who have reached the legal age will divert their supplies to younger friends. Of course, these young pushers will be in competition with many of the same people who are now pushing drugs in school yards and neighborhood streets.

Any attempt to limit drug use to any age group at all will create a black market, with all of the attendant crime and violence, thereby defeating one of the goals purported of legalization. That's also true if legalization is limited to marijuana. Cocaine, heroin and methamphetamine will be far more profitable products for the drug lords. Legalization of marijuana alone would do little to stem illegal trafficking.

Will airline pilots be able to use drugs? Heart surgeons? People in law enforcement or the military? Teachers? Pregnant women? Truck drivers? Workers in potentially dangerous jobs like construction?

Drug use has been demonstrated to result in lower work-place productivity, and often ends in serious, life-threatening accidents. Many drug users are so debilitated by their habit that they can't hold jobs. Which raises the question, if drug users can't hold a job, where will they get the money to buy drugs? Will the

right to use drugs imply a right to the access to drugs? If so, who will distribute free drugs? Government employees? The local supermarket? The college bookstore? If they can't hold a job, who will provide their food, clothing and shelter?

Virtually any form of legalization will create a patchwork quilt of drug laws and drug enforcement. The confusion would swamp our precinct houses and courtrooms. I don't think it would be possible to effectively enforce the remaining drug laws in that kind of environment.

Drug enforcement works

This is no time to undermine America's effort to stem drug abuse. America's drug policies work. From 1979 to 1994, the number of drug users in America dropped by almost half. Two things significantly contributed to that outcome. First, a strong program of public education; second, a strict program of law enforcement.

If you look over the last four decades, you can see a pattern develop. An independent researcher, R. E. Peterson, has analyzed this period, using statistics from a wide variety of sources, including the Justice Department and the White House Office of National Drug Control Strategy. He broke these four decades down into two periods: the first, from 1960 to 1980, an era of permissive drug laws; the second, from 1980 to 1995, an era of tough drug laws.

During the permissive period, drug incarceration rates fell almost 80 percent. During the era of tough drug laws, drug incarceration rates rose almost 450 percent. Just as you might expect, these two policies regarding drug abuse had far different consequences. During the permissive period, drug use among teens climbed by more than 500 percent. During the tough era, drug use by high school students dropped by more than a third.

Is there an absolute one-to-one correlation between tougher drug enforcement and a declining rate of drug use? I wouldn't suggest that. But the contrasts of drug abuse rates between the two eras of drug enforcement are striking.

One historian of the drug movement has written about America's experience with the veterans of Vietnam. As you may recall from the early 1970s, there was a profound concern in the American government over the rates of heroin use by our military personnel in Vietnam. At the time, U.S. Army medical officers estimated that about 10-15 percent of the lower ranking enlisted men in Vietnam were heroin users.

Military authorities decided to take a tough stand on the problem. They mandated a drug test for every departing soldier. Those who failed were required to undergo drug treatment for 30 days. The theory was that many of the soldiers who were using heroin would give it up to avoid the added 30 days in Vietnam. It clearly worked. Six months after the tests began, the percentage of soldiers testing positive dropped from 10 percent to two percent.

There may be a whole host of reasons for this outcome. But it demonstrates that there is nothing inevitable about drug abuse. In fact, the history of America's experience with drugs has shown us that it was strong drug enforcement that effectively ended America's first drug epidemic, which lasted from the mid-1880s to the mid-1920s.

By 1923, about half of all prisoners at the Federal penitentiary in Leavenworth, Kansas, were violators of America's first drug legislation, the Harrison Act. If you are concerned by the high drug incarceration rates of the late 1990s, consider the parallels to the tough drug enforcement policies of the 1920s. It was those tough policies that did much to create America's virtually drug-free environment of the mid-20th Century.

Drug laws can work, if we have the national resolve to enforce them. As a father, as someone who's had a lot of involvement with the Boy Scouts and Little Leaguers, and as a 30-year civil servant in drug enforcement, I can tell you that there are a lot of young people out there looking for help. Sometimes helping them means saying "no," and having the courage to back it up.

Let me tell you a story about one of them. He was a young man who lived near Austin, Texas, in the early 1970's. He had a wife who was pregnant. To protect their identities, I'll call them John and Michelle. John was involved in drugs, and one night we arrested him and some of his friends on drug charges. He went on to serve a six-month sentence before being turned loose.

Sometime after he got out, he and his wife came to our office looking for me. They rang the doorbell out at the reception area, and my secretary came back and said they were here to see me. I had no idea what they wanted. I was kind of leery, thinking they might be looking for revenge. But I went out to the reception area anyway.

John and Michelle were standing there with a little toddler. They said they just wanted to come in so we could see their new baby. And then Michelle said there was a second reason they came by. When he got arrested, she said, that's the best thing that ever happened to them.

We had been very wholesome people, she said. John was involved in sports in high school. He was an all-American guy. Then he started smoking pot. His parents couldn't reach him. His teachers couldn't reach him. He got into other drugs. He dropped out of high school. The only thing that ever got his attention, she said, was when he got arrested.

Meanwhile, John was listening to all this and shaking his head in agreement. He said that his high school coach had tried to counsel him, but he wouldn't listen to him. He said his big mistake was dropping out of sports. He thought that if he had stayed in sports he wouldn't have taken the route he did. But mainly, he said he took this route because of the easy availability of drugs and their widespread usage by his peers.

When I arrested those kids that night I had no idea of the extent to which I would ultimately help them out of their problems and influence their lives in a positive way. In 30 years of dealing with young Americans, I believe that John is more typical than not. His human frailties were magnified by the easy availability of drugs and by peer pressure; and his life was brought near ruin.

America spends millions of dollars every year on researching the issue of drugs. We have crime statistics and opinion surveys and biochemical research. And all of that is important. But what it all comes down to is whether we can help young people like John - whether we can keep them from taking that first step into the world of drugs that will ruin their careers, destroy their marriages and leave them in a cycle of dependency on chemicals.

Whether in rural areas, in the suburbs, or in the inner cities, there are a lot of kids who could use a little help. Sometimes that help can take the form of education and counseling. Often it takes a stronger approach. And there are plenty of young people, and older people as well, who could use it.

If we as a society are unwilling to have the courage to say no to drug abuse, we will find that drugs will not only destroy the society we have built up over 200 years, but ruin millions of young people like John.

Drug abuse, and the crime and personal dissolution and social decay that go with it, are not inevitable. Too many people in America seem resigned to the

growing rates of drug use. But America's experience with drugs shows that strong law enforcement policies can and do work.

At DEA, our mission is to fight drug trafficking in order to make drug abuse expensive, unpleasant, risky, and disreputable. If drug users aren't worried about their health, or the health and welfare of those who depend on them, they should at least worry about the likelihood of getting caught.

Thank you, Mr. Chairman and members of the Subcommittee, for the opportunity to testify before you today. I would be happy to try and answer any questions you might have.

Mr. MICA. I do have some questions. Let me start first with Dr. Leshner.

Doctor, there have been questions raised about the need for additional studies of the effect of marijuana. First of all, the effect of marijuana and the marijuana that we see out there now I think—is a little bit different than in the 1970's and maybe even the 1980's—what would be, in general, the damage to an individual?

The second part of that marijuana question would be, are there additional studies that need to be conducted or is there sufficient scientific, documented, factual evidence that there is, or is not medical benefit for the use of marijuana?

Can you address both of those parts?

Dr. LESHNER. The situation with the marijuana that is available on the street is that if you were to look at the average concentration of marijuana that is seized and analyzed, what you find is that in the last decade or so it has been relatively stable, on average, and that it is a bit higher, 1 or 2 percentage points of concentration higher than it had been in the 1970's.

What has changed and what I think is a point of concern for many people is that the diversity of forms and concentrations of marijuana has increased tremendously. So although the average may not be that much different, you now have tremendously potent marijuana and marijuana-like products that are available that might not have been available earlier.

As to the second question about the purported medical uses of marijuana, both the National Institutes of Health and, as General McCaffrey said this morning, the Institute of Medicine of the National Academy of Sciences have looked at this question in detail. Let me try and be precise in reporting what they have said. That is, there is not a body of scientific literature to suggest that marijuana is, in fact, a medicine.

However, having said that, both groups suggested that there might be ultimate use for some of the components of marijuana, for example, THC, and that research should be done in order to answer that question.

One of the issues that confront public health officials is that there is a lot of anecdote, intuition and common sense that appears to be driving medical practice in some parts of this country; and it is our obligation in the scientific community to try to provide a scientific answer to that. It is for that reason that these groups recommended that we enable research into the medical uses of marijuana.

We do have some ongoing studies that we are supporting looking at the potential use of marijuana for the treatment of AIDS wasting, for the treatment of cancer chemotherapy for those people who do not respond to existing medications, and for a potential use in analgesia.

Mr. MICA. Do you feel that you have sufficient resources this year to complete those studies?

Dr. LESHNER. We will complete those studies.

I need to say that for the National Institutes of Health we don't see this as a particularly high priority area, that is, as it goes through the peer review process, the majority of these studies have not received very high priority scores. That is why additional stud-

ies have not been funded. We therefore have provided a mechanism whereby bona fide research can be conducted by other entities. It would have to be judged to be genuine research through the Food and Drug Administration and NIH. Therefore, we might supply marijuana on a reimbursable basis.

Mr. MICA. Do you plan in the next fiscal year beginning in October of this year to fund additional studies?

Dr. LESHNER. We have not received additional proposals for support from the National Institutes of Health, and we are not actively soliciting such studies. If they come in the door, we will evaluate them. If they receive sufficient priority and merit, then we would consider funding them.

Again, we don't have any of those proposals before us that I am aware of at the moment. Maybe another institute does. Therefore, I think it is not very likely that we will fund many additional studies in the coming fiscal year.

Mr. MICA. Mr. Marshall, some of the prolegalization folks are taking to the airwaves and supporting various referendum initiatives. They are even publicizing in paid advertisements, this is a paid, multipage advertisement, to change drug control strategy and policy.

One of the things they recommend on the last page is effective drug control budget. They want to slice law enforcement by 50 percent. Do you think that is an effective strategy? What would it do if we sliced law enforcement by 50 percent?

Mr. MARSHALL. Mr. Chairman, no, I don't think that is an effective strategy. As I have mentioned in my comments, I believe that a combination of drug prevention programs and law enforcement really works.

I heard this morning either yourself, Mr. Chairman, or Congressman Gilman refer to some decreases in the amount of cocaine use in this country. I would offer, that law enforcement was a part of that reduction. Over the last 6 to 7 to 8 years, we have very effectively wiped out the Medellin Colombia cocaine cartel. We have continued our enforcement efforts against their successors, the Cali cartel. We really have that group in tremendous disarray right now.

I would submit that law enforcement success is a part of the reason that we have seen that reduction in the cocaine abuse rate. So law enforcement does work. I think it would devastate the total effort if we reduced our law enforcement programs.

Obviously, I think prevention and education are the long-term solutions to this problem; but, in the meantime, we have a lot of vicious, violent criminals that are preying on our citizens through drug trafficking; and those criminals need to be dealt with. The only way to do that is through law enforcement.

Mr. MICA. Two quick points in conclusion.

I think this Baltimore example which Tom Constantine, the Director/Administrator, had prepared shows that liberalization can be effective in population reduction, which took place in Baltimore. There can be some, I guess lessening in crime, although I don't think it has been very significant in Baltimore. But liberalization leads to addiction.

Now, this number we have here is from 1950, 300 heroin addicts in Baltimore, to 38,985. The gentleman from Baltimore, Mr. Cummings, has told me it is closer to 60,000. That would mean about 10 percent of the population of Baltimore. Do you think this is the way we should go?

I mean, your statistics point that liberalization has some effect, crime is down slightly in Baltimore, but we have, I would say, more than a few more addicts. Does liberalization lead to addiction?

Mr. MARSHALL. Mr. Chairman, I do not believe the liberalization approach is the way that we should go. I have already used the New York example, which I believe has resulted in less violence in that city. I would also use as an example a 1998 study by the Justice Department, I believe it is the ADAM report, that shows that arrestees for violent crimes tested positive for drugs at the following rates: 74 percent of arrestees for violent crimes in Atlanta tested positive for illegal drugs, 49 percent in Miami, 60 percent in Oklahoma City. I have given you examples of the homicides that were committed under the influence of drugs. I believe there is clear, clear evidence that drug use is accompanied by crime and violence, and I absolutely do not believe that liberalization is the right approach.

Mr. MICA. One final question. The Internet now has become a source for market activity. Our staff produced this little printout that shows price, drug price report, prices of Ecstasy and LSD and marijuana. I guess this information can be made public legally, although I am told additionally you can buy drugs now over the Internet, illegal drugs. Is the DEA taking any steps to go after folks that are dealing in this? And is it illegal to market and sell drugs in this fashion?

Mr. MARSHALL. What you have referred to there in terms of the prices and basically steering people toward sources, I would be hard-pressed to say that that is illegal. You get into freedom of speech issues and that sort of stuff. But as far as the selling of drugs over the Internet, obviously that is just as illegal as selling drugs in any other forum.

We have heard those same reports. We are in the early stages of evaluating and assessing that. We will be looking at that over the course of the near future.

Mr. MICA. Thank you.

I will yield now to the ranking member, Mrs. Mink.

Mrs. MINK. Thank you very much.

Mr. Marshall, following on the chairman's question about the use of the Internet to entice people to try drugs and indicate that it is widely available and where it could be purchased, is there any effort at the DEA to look at this as a special problem and, if so, what are you doing about it?

Mr. MARSHALL. We are actually investigating the reports that we have heard of the sale of drugs over the Internet. Quite honestly, we are in the early stages of that, and we do not have a handle on that. I would like to respond to that at a later date after we have had a chance to completely look into it.

Mrs. MINK. But it would seem to me that it would be important for the DEA to have a cyberspace cop section that would be looking

at all of this and keeping on top of it and making a search to see who is doing all of this and whether, in fact, sales are taking place.

Mr. MARSHALL. We have requested in our 2001 budget funding for a computer forensics program. What you are suggesting would become a part of that computer forensics program. We have a limited capability in that area right now, but we hope to increase that over the next couple of years through the budget process.

Mrs. MINK. Currently we are discussing Internet sales of guns, Internet sales of wine and beer and hard liquor. So I think this suggests a new area to begin some very serious studies and suggestions for legal efforts on the part of the Federal Government to intercept the growth of this particular industry.

I am very distressed about it. I have a bill myself that bans the Internet sale of guns. It would seem to me that we could easily expand it to this if there is any gap in the law that prevents you from getting into this field at all.

Mr. MARSHALL. I agree totally with everything you have said.

I would point to a particular issue with law enforcement, and it is going to become more of an issue as Internet commerce grows, and that is the issue of encryption. We are sort of at a crossroads right now. We have a need to preserve law enforcement's legitimate court-ordered, court-authorized capability to intercept both telephone communications, fax communications and Internet communications that involve criminal activities. We are, frankly, in some danger of losing that. That is an issue that the law enforcement community has had a lot of dialog with Congress and industry on. It is an issue which is very important to law enforcement.

Mrs. MINK. The statistics that you brought forth about the number of people in prison today who have a drug use connection is very startling. Could you tell the committee how many major drug traffickers are in prison today?

Mr. MARSHALL. I would have to get that actual information as to how many are in prison.

I can tell you this. The Drug Enforcement Administration and our local law enforcement partners who are working with us through formalized task forces arrested some 33,000 drug traffickers in the most recent fiscal year, 1999. I could not tell you how many of those are actually in prison, but we do target the major traffickers, the major command and control figures, the communications managers, the money launderers, those kinds of people.

Among those 33,000 that we have arrested, we believe that they are, for the most part, major drug criminals. If you would like, I will try to get you those statistics.

Mrs. MINK. I would appreciate having that for the record, Mr. Chairman, when you are able to assemble it.

Now, if you were able to arrest and convict those 33,000 drug traffickers, what percentage of the drug traffic in America would that then represent?

Mr. MARSHALL. That is a very difficult, if not impossible, question to really answer. The reason it is difficult to answer is that when you look at drug production in the aggregate, you have to consider a number of things. You have to consider that there is a demand for drugs at a certain level in the United States. There are numbers on this. I don't have them with me.

If you assume a certain level of demand, we know that the traffickers have an actual production level of drugs that is in excess of that demand. So you would think that would be a simple equation, you bring that down below the demand, you impact availability of drugs.

But what we also have to consider is that somewhere above the actual production is production capability. The traffickers have this built-in capability to account for loss and spoilage and law enforcement seizures and that sort of stuff. So what you have to do is really impact the production capability, not the actual production, before you can impact the demand level. And because that production capability so far exceeds the demand level, it is really hard to say—it is probably impossible to say what percentage those 33,000 arrested represent.

Mrs. MINK. What you are really saying is, even if you put all of them in jail, there will still be traffickers to replace them that will be out there to sell whatever else is being produced?

Mr. MARSHALL. As long as there is widespread drug use. That is where the prevention side of the equation comes in.

Mrs. MINK. That is the reason for my question, is that when we are dealing with the subject of youthful potential users, say, of marijuana, for instance, the whole issue that I am confronted with when I talk to teenagers about this is that they would say, but it's so easy to get, it's down on that street corner or over at this shopping center or wherever. So I always confront the question of what can we do as a society to stop this easy access, easy availability? And so I go back to the trafficking and how this thing moves through our society. Unless we can come to grips with that issue, it is tough on the other aspect, of keeping our kids away from it.

Mr. MARSHALL. Here is what we can do, in my best professional judgment. It really has to be a two-pronged attack. We have to do the prevention and the demand reduction side of the equation as the ultimate long-term solution. But in the meantime, as I mentioned, we have these major narcotics traffickers. We have the violence, we have the crime that is associated with drug use, and we have to go after those criminals. We have to punish those criminals.

What we do in the DEA and I think most law enforcement agencies, we try to target the most violent of those criminals. We try to target the ones who are moving the largest quantities of drugs. And, frankly, law enforcement resources are limited across this country. We can never arrest our way out of the problem. I don't think any law enforcement professional would say that we could. But it is a part of the equation that we have to address because of the crime and the violence.

Mrs. MINK. Moving to the prevention end and addressing it only to the teenager, the student in school, what is the most effective thing that we can do to prevent our young people from making that first mistake, in trying marijuana or some other drug? What is the most effective thing that we can do here in the Congress or in the relevant agencies to which this problem is assigned?

Maybe Dr. Leshner can answer that.

Dr. LESHNER. A great deal of research has been done on the prevention of drug use; and, sadly, there is no simple solution to the

problem, of course. But we do know that comprehensive programs that involve multiple parts of the community that are all sending the same message and that are sending those messages repeatedly are effective in preventing drug use.

General McCaffrey showed some very impressive graphs about changes in drug attitudes and changes in drug use rates. We have begun to see a change in attitudes, to see the beginning of a change in use rates. Some of that, we believe, is a result of very sophisticated prevention programming that gets initiated very early. We have to get kids before they are in middle school, and then we have to give them boosters, just like any other vaccination program. And so this programming is never simple, and it does have to be comprehensive.

One of the things that has happened in this country is the evolution of antidrug coalitions around the country. A major goal that they have had, and that I think they have done an outstanding job of, is having integrated approaches that bring in not just the schools, not just the parents, not just the churches, but to mobilize an entire community in a single strategy. As far as we can tell from the scientific research that has been done, it is an effective strategy.

Mrs. MINK. Thank you, Mr. Chairman.

Mr. MICA. Thank you.

I now recognize the gentleman from Georgia, Mr. Barr.

Mr. BARR. Thank you, Mr. Chairman.

First of all, Mr. Marshall, as always, thank you and the men and women of the DEA for the outstanding job that you do. I and my constituents deeply appreciate it.

Put yourself, if you would for a moment, hypothetically, in the position of a State prosecutor in a State in which there are laws against pedophilia and rape. Would you take kindly to somebody who comes out with a study and says that pedophilia is OK; therefore, I'm going to go out there and spend huge sums of money trying to make it legal and encourage people to engage in it, or rape?

Mr. MARSHALL. No, sir.

Mr. BARR. Would you have any hesitancy in taking offense at that, notwithstanding their claims that this is simply an exercise of first amendment free speech?

Mr. MARSHALL. I would take great offense, and I think it would be a ridiculous argument.

Mr. BARR. Do you see that much of a distinction between those arguments and the arguments of the advocates of legalized drug usage?

Mr. MARSHALL. Being a professional 30-year law enforcement person, Congressman, I have to confess that I do not see much difference in it.

Mr. BARR. Thank you.

One of the things that I look at, for example, is consistency, and I think that is very important as a professional law enforcement agent. Recently, it has come to our attention that the U.S. Department of Defense is finalizing regulations to allow for the use of peyote on military bases by military personnel for so-called religious purposes. Is it your understanding that peyote remains a Schedule

I controlled substance under the laws of the United States of America?

Mr. MARSHALL. Congressman, I believe that it is. However, I believe there may be some religious exemptions for Native Americans. I am not aware of the issue with the Department of Defense. But I believe it does remain a Schedule I. If I could verify that and get back to you.

Mr. BARR. Because, it is in the criminal code. If in fact, the military allows this and if, thereafter, somebody in DEA were to come to you and say, I believe as part of my religious practice and my Native American heritage that I should be allowed to smoke peyote, would you see that as inconsistent with their duty as a sworn law enforcement officer with jurisdiction to enforce the controlled substances laws of the United States?

Mr. MARSHALL. I'm sorry, are you talking about military, sir, or law enforcement?

Mr. BARR. No, if there were a DEA agent who came to you and said, I believe that as part of my religious practice, what I deem a religious practice, I'm going to start smoking peyote. I understand that it is now allowed in the military. Would that to you be consistent with or inconsistent with their sworn duty as a law enforcement officer with jurisdiction over enforcing our Federal drug laws?

Mr. MARSHALL. Congressman, I would be very, very troubled by that. However, I think I would have to look at the religious exemption and the origins of that law to make a final decision. But I would be very, very troubled with that.

Mr. BARR. I would hope so, and I would certainly think so.

Dr. Leshner, I referred earlier to this volume, Marijuana and Medicine, that you may or may not be familiar with. We have inserted it into the record. There is quite a lengthy discussion about a lot of the harmful effects of marijuana usage, including several chapters here on its very serious detrimental effect on reproduction, human reproductivity, and in particular its effect on—and they have some very interesting slides, similar to the scientific slides that you presented here—on spermatozoa and the abnormalities that result from particularly extended marijuana usage. Are you familiar with those studies?

Dr. LESHNER. I am somewhat familiar with them. I am not sure I am familiar with all of the studies that have been done, but a great deal of work has, of course, been done on the metabolic consequences of marijuana use.

Mr. BARR. Are you familiar enough to give us your opinion on whether or not there are detrimental effects on human reproductivity by the extended use of marijuana?

Dr. LESHNER. I think it is not clear, sir. There is a substantial body of literature in animal subjects that suggests that Delta-9 THC can decrease pituitary prolactin and can, in fact, interfere with cycling in female rodents. I think some studies have been done in humans that confirm that kind of interpretation. But, as a scientist, I have to say that I am not sure all of that research has actually been done.

Mr. BARR. I would recommend you, if you could, take a look at some of the research in here. I am certainly not a medical doctor

or a scientist, but they present some compelling—both textual material as well as some graphs and pictures showing that there indeed seems to be a very clear link.

Could you just very briefly explain—I noticed the chart that you have up here on methamphetamines. We have been focusing particularly this morning on marijuana, maybe to the detriment of some of these other drugs. Could you—and you may have already done this. If you have, I apologize. But by the same token I think that this bears repeating.

Could you just briefly explain for me and for anybody who might be listening or read the record of this case what that depiction of the four—they are not photographs but brain scans regarding methamphetamine use represents?

Dr. LESHNER. They are—and if you will indulge me, given the comments earlier this morning about Ecstasy, I would also like to take just a minute and tell you about the other poster as well, which I did mention in my oral statement. The measure here—bright colors are more, dull colors are less—is the ability to use a substance in the brain called dopamine. Dopamine is necessary for normal cognitive functioning and the normal experience of pleasure. It is a very important neurochemical substance.

What you see on the left is the ability to bind dopamine in a control, in this case a normal individual. The second scan is the brain of the methamphetamine abuser 3 years after that individual stopped using methamphetamine. The third is a methcathinone addict 3 years later. The fourth is a newly diagnosed Parkinson's disease patient. As you know, Parkinson's is a dopamine abnormality as well, although it affects a different part of the brain.

What is significant here is that you are seeing a very long-lasting effect of drug use that persists long after the individual has stopped using the drugs. What is important about the particular brain change is that it could account for some of the mood alterations and certainly the psychotic-like behavior that persists after methamphetamine use long after the individual stops using it.

The other chart, which actually you may have seen a related study reported in the press just yesterday, is the first demonstration in humans—this is the first demonstration in humans on methamphetamine, by the way—the first demonstration in humans of the persistent effects of Ecstasy use. MDMA is Ecstasy. What you are seeing here on the top is a control individual, a normal individual. The measure here is the ability to bind another neurochemical called serotonin. Serotonin is critical to normal experiences of mood. As you may know, antidepressants can modify serotonin binding.

So there is a normal individual on top. The bottom is an Ecstasy user. In this case it is 3 weeks after that individual has stopped using Ecstasy. What you are seeing here is a persistent decrease in the ability of the brain to bind this very important neurochemical substance.

The study published yesterday actually showed in primates—I am not sure how you would do this in humans—but showed in primates a virtually identical effect 7 years after the primates were given MDMA. So that the point that I have been making is that drug use has an effect not only acutely, not only in the chronic use

condition, but that it has persistent effects that last long after the individual stops using drugs.

Mr. BARR. Would the same hold for extended marijuana usage?

Dr. LESHNER. We don't know in detail.

We know in great detail—and the question was asked earlier this morning, and I would be pleased to submit information on that for the record—we know in great detail the mechanisms by which marijuana exerts its acute effects in the brain, its short-term effects. We do know that in long-term marijuana users there are persistent behavioral effects that persist 48 to 72 hours after the individual stops using marijuana. But, as far as I know, no studies have been done analogous to this that are looking so far out after marijuana use.

Mr. BARR. Thank you, Dr. Leshner. Thank you, Mr. Marshall.

Mr. MICA. I would like to thank both of you. We have additional questions which we would like to submit to you for the record. I would also like to leave the record open for at least 2 weeks for you to submit additional information.

Someone commented that if we could get these charts to every parent in America, we probably would have a lot less drug use, when people could see the actual effects on their body and on their brains.

Dr. LESHNER. We are trying, sir. We are trying to do exactly that.

Mr. MICA. It is very revealing. Quite shocking.

I would also be interested if you can supply us with any similar information on the effects of marijuana, if you do come across that. I think that would be interesting to have. Also, these other drugs we will put in as part of the record.

Dr. LESHNER. We will provide you with information on that.

Mr. MICA. I would like to thank both of you. We will submit additional questions.

I would like to call our third panel at this time and excuse the second panel.

Our third panel today consists of Mr. James McDonough, the director of the Office of Drug Control Policy of the State of Florida; Mr. Scott Ehlers, the senior policy analyst at the Drug Policy Foundation; Mr. Robert L. Maginnis, a senior director of the Family Research Council; Mr. David Boaz, executive vice president of the Cato Institute; and Mr. Ira Glasser, the executive director of the American Civil Liberties Union.

I am pleased that all of you have joined us today. As I indicated before, our subcommittee is an investigative and oversight panel of Congress. We do swear in our witnesses. If you wouldn't mind standing and raising your right hands.

[Witnesses sworn.]

Mr. MICA. I thank the witnesses. They have all answered in the affirmative.

I will also point out, most of you are new to the panel, we do ask that any lengthy statements or additional information you would like to submit to the record, we do so upon request, and that we try to limit our oral presentations to 5 minutes. You will see a little light there. We try to be a bit flexible.

With those comments in mind, I would like to first recognize and welcome to our subcommittee Mr. James McDonough, the director of the Office of Drug Control Policy created by the new Governor of the State of Florida. Mr. McDonough, welcome, and you are recognized, sir.

STATEMENTS OF JAMES MCDONOUGH, DIRECTOR, OFFICE OF DRUG CONTROL POLICY, STATE OF FLORIDA; SCOTT EHLERS, SENIOR POLICY ANALYST, DRUG POLICY FOUNDATION; ROBERT L. MAGINNIS, SENIOR DIRECTOR, FAMILY RESEARCH COUNCIL; DAVID BOAZ, EXECUTIVE VICE PRESIDENT, CATO INSTITUTE; AND IRA GLASSER, EXECUTIVE DIRECTOR, AMERICAN CIVIL LIBERTIES UNION

Mr. MCDONOUGH. Thank you very much, Mr. Chairman. It is an honor to be here.

I would like to submit my statement for the record and save you the time not going through it.

Mr. MICA. Without objection, it will be made part of the record.

Mr. MCDONOUGH. I just wanted to say a few things about my observations of drug use in the United States and particularly in the State of Florida where I now, as you have pointed out, have been tasked to coordinate all drug efforts, to bring down that abuse rate. Prior to that time I worked here in Washington in the National Drug Control Office to see what I could do to help the national concerns about drug abuse.

I will tell you that Florida has a bad problem with drugs. It has enough of a problem right now that I feel any legalization of drugs would only exacerbate drug abuse further. I note that we have by my account some 8 percent of our people in Florida currently using drugs. This does not fare well compared to the national average, about 6 percent.

I have looked further. The last existing surveys in Florida which date to 1995, show me that we are about 25 percent above the national average with our youth use. So we have a problem across the board, and we have a particular problem with youths.

I think one of the reasons why we have such a problem is the vast supply of drugs coming through the State. I have taken a look at that, over the first 90 days that I have been in office down there, by going around the State. What I see, quite frankly, is shocking. In this past year, we note that the heroin death rate in Florida has gone up 51 percent in only 1 year. This is just an enormous rise in the statistics in only 1 year. It makes one shudder as to how it is going to look over the long term.

The cocaine-related deaths in the State are also up a horrific extent. We are talking about in the last 6 years, a 65 percent increase in the cocaine-related death rate. This now means that with over 1,100 deaths a year, that statistic exceeds the murder rate in Florida.

Having said that, indications are that a big part of this is related to the amount of drugs flowing through the State. I have a note that last year, Customs reported that some 60 to 65 percent of the cocaine it seized in total, nationally, was seized in Florida. I am trying to point out that there are several factors for the abnormal

rate of drug use in the State. But one of the factors I am certain is the supply of drugs.

I might add that I have spent most of my initial time in the State going around the various areas meeting with the civic leaders, the local leaders, the media, and a significant portion of the time getting into the treatment centers to see what the people who are addicted to drugs have to say. It is remarkably revealing to me, something I also saw when I worked at the national level.

When you go into a treatment center where you are seeing people in their 20's, 30's or 40's, by the way some in their teens who have really suffered a lot in their lives and brought a lot of suffering on other people, who have committed the majority of the crimes in the State, there is a couple of messages that they give you.

The first message is, and I don't endorse this message, but the first thing they tend to tell you as a group is, "I'm a wreck. I have hurt a lot of people in my life. I'm a failure."

The next thing they tell you—they don't really tell you, they ask you, they ask you for help. They say, unless you get me the treatment, I'm a goner. I don't want to die. Please, please, we need help, or I need help.

When I ask them what got them started on drugs, it invariably goes back to their youth. Usually, it is their early youth. They tell me, yeah, I smoked; yeah, I drank; marijuana was my initial drug. They tell me they started this at 12, 13, 14.

When I ask them, well, would it have been any different if these drugs were legal, they say, "Absolutely not. The last thing we need is the legalization of marijuana. It is marijuana that got me here." Probably that phrase is the one I hear most often. I will tell you I have yet to hear from any addict talking to me saying, you know, if only drugs had been legal, I wouldn't be in the shape I am today.

I might add, on a much more graphic note, when I listen to parents, I have no parent of a child that has suffered from the abuse of drugs, died from an overdose or caused untold grief on the family say, "if only the drugs had been legal, my child would not have been caught up in this."

So my observation is, the last thing Florida needs, and I would extrapolate that, the last thing the country needs, is the legalization of illicit drugs. Thank you.

Mr. MICA. Thank you.

[The prepared statement of Mr. McDonough follows:]

**TESTIMONY OF JAMES R. MCDONOUGH BEFORE THE GOVERNMENT REFORM
COMMITTEE'S SUBCOMMITTEE ON CRIMINAL JUSTICE, DRUG POLICY AND
HUMAN RESOURCES**

**DIRECTOR, OFFICE OF DRUG CONTROL
STATE OF FLORIDA**

16 JUNE 1999

Chairman Mica, Congressman Waxman, thank you for the opportunity to testify before the Committee on the subject of drug legalization.

Legalizing drugs is a notion to which I am steadfastly opposed. I came to this position after years of observation and study of the nature of drug addiction, and its horrific consequences for the addicted, their families, and society. The immense costs that drug addiction exact on our nation were driven home to me during my tenure as Director of Strategy for the White House Office of National Drug Control Policy. My recent experiences as the Director of Florida's Office of Drug Control have only served to reinforce my beliefs on this matter.

Florida does not need legalization to help it bring down its drug abuse problem. What it does need is a coordinated strategy with the right leadership and resourcing behind it that will bring down both the demand for and supply of drugs.

Governor Jeb Bush has made it clear that doing just that is a high priority for his Administration. With him is the Florida Legislature, whose leadership in both the House and the Senate has been lending their support to decreasing drug abuse in the state. The Judiciary has also given its support to some of the more innovative ways to break the nexus between drugs and crime, such as with the system of drug courts in Florida, the most extensive in the nation with 32 different drug courts in full operation or in the early stages of ramping up. And the Governor's wife, Columba Bush, has also lent her persona to a number of public service announcements that inform and educate children and their mentors about the dangers of illegal drugs.

This sort of leadership is timely, because Florida's drug problem is serious. Statistics show that Florida's children use drugs at a rate 20 percent higher than the rest of the nation. Indeed, the overall drug use rate in the state (for adults and children) is at about 8 percent, compared to the national average of 6.5 percent. Last year, Florida's death rates from heroin abuse increased by over 50 percent from the year before; cocaine related deaths have increased 65 percent, bringing the total of those killed by drugs to more than the entire murder rate for the state.

One of the reasons for this abnormally high rate of usage is the large supply of drugs that enter Florida from beyond its borders. Last year, Florida's seaports seized between 60 to 65 percent of the entire amount of cocaine seized in the United States, more of a sign of the large volume of drugs coming in than of our efficiency in catching them. The Office of National Drug Control estimates that as much as 30 percent of all the drugs that enter the United States come across Florida's international boundaries. Florida lies at the receiving end of several major transit routes for heroin and cocaine drug traffickers. Not only do a disproportionate amount of drugs make their way into our state, a large share of the money laundering transactions also take place on Florida's soil. We have a serious problem, and we will need the help of the federal government to protect our borders and defend ourselves against the onslaught of the drug traffickers.

But Florida has also been well-served by its citizens who have decided to take a stand against illegal drugs. Throughout the state, community coalitions and neighborhood associations have stood up to the menace of illegal drugs. And where they have taken a stand, the results have been impressive. Miami-Dade County, for example, has brought their drug abuse rates down to less than one half of the rest of the state by bringing together prevention, education, intervention, and treatment efforts together under its Coalition for a Safe and Drug-Free Community and formed partnerships with law enforcement agencies and the business community. In St. Petersburg and Tampa, agencies like PAR and DACCO work in conjunction with the very active local drug courts in providing treatment to non-violent addicted offenders and consequently bringing down recidivism crime rates appreciably.

There are nonetheless organizations and individuals in the United States who favor legalization, seemingly in spite of the efforts of so many concerned Floridians, as well as the efforts

of countless thousands of other concerned and compassionate citizens across our nation, who understand that keeping harmful drugs illegal is the only sensible way to curtail their wake of destruction. But the pro-drug advocates persist despite the clear rejection of the idea of drug legalization by millions of Americans, and the obvious negative consequences of drug addiction.

These “legalizers” span the philosophical spectrum, and their motivations stem from a variety of views, rationales and desires. Some legalizers argue (wrongly) that it is our only viable alternative, since all attempts to eliminate drug abuse in the United States have failed. Others in the legalization camp argue – contrary to empirical evidence – that drugs do not harm people, rather that the harm comes from the prohibition of drugs. Many advocates of legalization are well intentioned, believing that their approach will ultimately help – not hurt – our society. A few are less well intentioned, being driven in some instances by a desire to see drug use expand. However – and I want to state this as emphatically as I can – **the legalizers are wrong**, and their advocacy for the legalization of drugs threatens the well being of our nation.

Simply put, drugs are not harmful because they are illegal. They are illegal because they are harmful. Indeed, a high proportion of society’s ills – crime, family disintegration, child and spouse abuse, workplace productivity losses, community deterioration and violence, and, ultimately, the physical and financial ruin visited on millions of our fellow citizens – can be directly tied to the use of harmful drugs, and not to the laws that wisely prohibit them.

Arguments that purport the opposite view are disingenuous and shopworn. Whether libertarian in philosophy or pseudo-logical in pretext, the tone of legalization advocates is strikingly similar – arrogant dismissal of the views held by the majority of Americans that drugs are a danger to our citizens, ruinous of our neighborhoods and communities, and non-sensical as “entertainment.” Let me take a few moments to briefly examine – and dispel – some of the usual claims put forth by the legalizers:

Legalizers will claim that the “drug war” has been lost, that we need to stop wasting resources in fighting it. In reality, The National Drug Control Strategy explicitly rejects the “war”

metaphor. The Strategy points out, accurately, that drug use in America is down by 50% since 1979, and cocaine addiction is down by 75% since 1982. These statistics clearly demonstrate that when we as a nation resolve to bring down drug abuse, we succeed.

The legalizers will claim that the fact that alcohol and tobacco, both legal substances for adults, cause so much harm to society suggests that we make drugs legal as well. A simple response to this claim is that it would seem, according to their logic, that we can't get too much of a bad thing. Moreover, the analogy is false. Law enforcement experts and prison statistics indicate that drug abuse is directly or indirectly related to upwards of 60 to 80 percent of crime in America.

Whenever drug use is high, so too is crime. For example, in neighborhoods that have elected to sponsor so-called "needle-exchange" programs (in effect, needle-give away programs where drug abuse is de-facto decriminalized), prostitution, thefts, burglaries, and other crimes against property skyrocket. And oh, by the way – drug abuse and, more often than not, HIV infection rates also go up. The simple reality is that people addicted to drugs will do whatever it takes to get the money to buy the drugs they crave. Making drugs legal won't change that reality. It would only lead to increased drug usage, more addicts, and worsened social problems.

Legalizers will also claim that other countries, such as Holland or Switzerland, have shown what enlightened government policies towards drugs can do. The reality is that the United States is neither Holland nor Switzerland. We should not attempt to model our drug attitudes after what the majority of their neighbors, as well as a sizeable percentage of their own citizens and drug experts, see as abysmal failures. The current edition of Foreign Affairs has an excellent article by Larry Collins on the Dutch experience and the damage done by the presumably good intentions of "harm reduction" and "decriminalization" advocates. The experience of countries that have tried the legalization approach has been increased crime, overdoses, and youth usage rates.

Government should not be in the business of stupefying its citizens and sedating its drug addicts unto death. What glimmer of compassion, what spark of respect for the sanctity of human dignity lies in policies of "heroin maintenance?" Spare our great country such folly.

A favorite claim of legalizers is that marijuana is not a “gateway” drug. It causes no harm, they say. The simple truth is that the correlation between marijuana use, and the use of other drugs, such as heroin and cocaine, is overwhelming. Joseph Califano’s Center on Addiction and Substance Abuse study concludes that for children who smoke, drink and use marijuana, the probability they will “graduate” to heroin or cocaine as an adult **is eighty times greater**. According to the National Drug Control Strategy, youth violence, property crimes, and truancy rates in school go up in direct proportion to the frequency of marijuana use. In scores of treatment centers, when I have asked resident addicts how they began their nightmare with drugs, the overwhelming answer is, “Marijuana.” When I ask them if it is a harmless drug, the overwhelming response is “No, it got me to where I am today.” It is for good reason that Barry McCaffrey, the nation’s drug czar, warns that marijuana is our most dangerous drug.

Legalizers will often attempt to draw a historical analogy by claiming that the Prohibition era is an example of why we should legalize drugs. Look at all the trouble it caused. Prohibition brought us Al Capone and tommy guns. When Prohibition went away, so did high crime rates. In fact, after the end of Prohibition crime in general went up, along with a deterioration of public health. Indeed, the simple truth is that crime rates have been coming down in America for the past decade. Unfortunately, crimes committed by juveniles is the one area which has experienced increases during this same period of overall decline in crime rates. It is no coincidence that this increase has occurred at the same time that youth drug use has been increasing. It is incontrovertible that drugged individuals or those needing money for drugs commit crimes at disproportionate rates. The overwhelming majority of child abuse and spouse abuse cases can be tied to drugs and alcohol abuse. That legalization would bring down crime is wishful thinking.

Another shopworn claim that legalizers frequently use is that if drugs are virtually ubiquitous in our society, then why not reap a windfall in potential revenue by legalizing drugs and then taxing them? As obvious as any number of responses are to this ridiculous assertion, let us first consider the plausibility of international narcotics cartels giving up their phenomenally

lucrative activities to accept lower profits while simultaneously paying taxes to the United States Government.

It is important to remember that even with regulation, legalized gambling, for instance, has not eliminated illegal gambling. Even more ludicrous to contemplate, under the banner of legalization, would be the effort required in creating a regulatory bureaucracy for administering and enforcing tariffs on both foreign and domestic producers. There would also be a myriad of issues involved with setting minimum use age, what drugs would be available and to whom, and countless other matters. Such endeavors would be bad policy, poor policy, and disastrous social irresponsibility.

Illusory tax receipts notwithstanding, we as a society would pay out enormous increases in increased medical expenses due to the incredibly deleterious effects drugs wreak on people. It is doubtful that increased availability, potentially lower cost and the removal of criminal sanction would not foster an explosion in usage. While government taxes tobacco, for instance, tax receipts are only a fraction (as little as one-sixth according to one study) of the costs to society exacted by the effects of smoking -- and illegal drugs are typically far more injurious to one's health and life style than cigarettes.

The myths offered by the legalizers feed and reinforce the misperceptions generally held by the public as regards the debate over illegal drugs. For instance, many citizens believe that drugs are a problem only for certain parts of our culture -- inner city residents, the poor, those lacking education, and the otherwise disadvantaged. Somehow, those who hold such views deny their own family's risk to the prevalence of drugs.

The simple reality is that drugs threaten our entire society. No neighborhood is safe. The nodal heroin overdose fatality is a white male, and some of the heaviest concentrations of drug addiction can be found amongst some of this nation's most upscale social and professional enclaves, whose denizens mistakenly believe that they can "handle it." The children of the well to do are more apt to try drugs than the poor. Minorities are less inclined to use drugs than are whites.

Drugs are everywhere and contaminate all segments of our society, no matter what an individual's income, educational background, or ethnicity. Legalizing drugs, therefore, would only exacerbate their availability. As exposed as our children are today to the threat of drug abuse, making drugs legal would only make them more available to youth.

Nor is it true, as so many assume, that most drug users are unemployed. Research shows that over seventy percent of those who abuse drugs are employed. Productivity losses due to absenteeism, inefficiency, and workplace accidents already cost businesses egregious losses. Consider the effects of legalizing drugs on American enterprise. It is prevention and treatment – not legalization – that would better help employees, and thereby the businesses they work for.

Faced with such realities it is hard to advance to an educated public the specious arguments for more drugs. Instead, legalizers are forced to turn to a variety of ploys to gain support for a pro-drug agenda. One of these ploys is “marijuana as therapy.” Step One is to label pot as “medical marijuana,” much like granddad labeled his “medicinal whiskey.” Step Two is to cry foul against medical research protocols that demand peer review to ensure scientific worthiness for proposed research projects (most medical scientists, admittedly, would rather research more promising pharmaceuticals) while citing endless anecdotes – usually cast in emotive compassion for the afflicted – that “proves” smoked marijuana is a health aid. Steps Three and Four are to pour money, big money, behind grass roots campaigns that appeal for votes for more “medicine” for the ill and suffering, while seizing upon any suggestion at all that THC, the active chemical component of marijuana, may lead to a relief of symptoms, and then implying that relief applies to the underlying illness. The result is a false claim that medical science is supportive in decreeing marijuana as the only smoked “medicine” in American pharmacological history.

The spin put by the legalizers on the recent Institute of Medicine review of existing literature on marijuana research is a case in point. This reputable study by the Institute saw little future in smoked marijuana because of its negative side effects, doubtful efficiency and uncertain safety. Nevertheless, supporters of smoked marijuana nevertheless jumped on the suggestion in the report

stating that, in certain extreme conditions and only under controlled chemical conditions, should limited use of marijuana be allowed. Dropped from their depiction of the study were key factors of the report: that THC is readily available now as a prescription drug (i.e., Marinol); that several anecdotal claims of relief were unsupported (e.g., glaucoma is not relieved by marijuana); and that research should continue so that a non-smoked, vaporized, purified inhalant might be developed in lieu of smoke from an impure weed. In short, those who so plainly wrap themselves in sacred appeal to marijuana as medicine continue to gloss over the findings of medical science that what benefit may be found in the marijuana plant is limited to THC, and then only when purified, measured, and delivered in non-smoke form. So far, what the marijuana advocates have succeeded in doing is propagandizing their pro-drug agenda as socially acceptable even while ensuring that research efforts (with greater potentials for aiding the many ailments they claim marijuana will help) see their available funds diverted to the less promising, more dubious marijuana fields.

In such ways, marijuana (now recast as medical in nature) serves as a stalking horse for the legalization of drugs. The real arena is not medical at all, but political. And politics is driven by money, of which ample amounts will be made available to carry the legalizer's case into ever more state campaign initiatives. Why so much money is dedicated to such a dubious cause is a vexing question. Surely there are better things great wealth can buy.

We should not, however, be discouraged. Americans have an uncanny ability at getting at the truth over time. We now have several states whose electorates have been convinced to advocate "medical marijuana." We have been down such paths before. Alaska, for example, decided in 1975 to "decriminalize" marijuana for personal home use, only to see that decision reversed in 1990 by popular referendum as its citizens recoiled in horror at the resulting rise in adolescent drug abuse during the intervening fifteen years.

Unfortunately, the most harm caused by the perception that "pot is ok" is most clearly seen in youth attitudes about the potential harm of marijuana and drugs. In a decade that has seen heavy outside campaign money back electoral appeals for medical marijuana we have seen youth

perceptions of the dangers of drugs decrease. As a clarion predictor of future behavior, youth attitudes clearly delineate future youth use rates.

This seductive change in attitude is perhaps best represented in the growth of the Rave phenomenon. Rave clubs target young people with an appeal to all night dancing and partying in an atmosphere of heavy “techno-music” and psychedelic light shows. The typical age range at a Rave is late teens through early twenties, but it is not uncommon to find children as young as twelve at these events. Attendance at Raves typically ranges in size from as few as a hundred or so young people dancing in small regular clubs which advertise “no alcohol” and stay open after hours, to a couple thousand youth in outdoor Raves which resemble rock concert events. Oftentimes, Rave parties are advertised well in advance of the actual date, giving time for the word to spread through the community.

While many American youth are initially drawn towards the cachet of what Rave clubs represent (this avant-garde social phenomenon originated in the U.K. in the late 1980’s before moving on to North America), many parents mistakenly see these clubs as “safe” venues, alternatives to roaming around on the unsafe streets. What makes Raves dangerous however is that they serve to popularize reckless youth attitudes towards not only newer so-called designer drug use – drugs like ecstasy and GHB - but also more established illegal drugs such as heroin, crack cocaine and marijuana.

Perhaps the most disturbing aspect of the Rave phenomenon, however, is the manner in which drug use at these dances is acknowledged, abetted and profited from by the Rave club owners. Rave’s typically sell – at usually very high mark-ups - a rather bizarre assortment of items not normally associated with drug abuse, such as pacifiers, Vicks inhalers, colored light strips and glasses, as well as certain types of hard candy, like lollipops. However, when viewed in light of how these seemingly innocuous items enhance the effects of drugs like Ecstasy, it is clear why the promoters on the premises routinely sell these items.

Much like the drug cartels in their attitude and focus, the behavior of the Rave club operators clearly shows the cynical marketing of a seductive lifestyle and attitude which, in effect, strongly facilitates drug abuse by our children in the name of quick and substantial profits for the owners.

Even with clear signals from responsible civic leadership to America's youth that drugs are not safe and therefore illegal, such repellant environments as present in modern day Rave clubs have achieved a strong appeal to the young. Legalization of drugs like marijuana and others would only tend to exacerbate youth attitudes that drugs were "fun" and acceptable for personal use.

CONCLUSION

Despite many concerned Americans best efforts to educate the public about the danger of illegal drugs, there is a concerted effort by a broad spectrum of individuals and organizations to push a pro-legalization agenda. Drugs are illegal simply because they are harmful. Despite this basic truth, various myths, as outlined above, continue to be perpetrated by the legalization and "harm reduction" forces on a public which, though largely uneducated as to specifics, remains broadly anti-drug in its beliefs.

At the core of legalizer attempts to make drugs legal and available is the concept of "normalization." The idea is to make drug use seem normal, as opposed to the abnormality it truly is. Normalcy is the underlying theme in the many recitations by the legalizers: alcohol's legal, why not drugs?; the Dutch do it and it has not hurt them, why shouldn't we try it?; marijuana is medically beneficial, so why outlaw it?; people are using drugs anyway, so why make them criminals by prohibiting their drug use?; drugs are everywhere, so why not regulate their use and let the government get some tax revenue from its sale?

There is little subtlety in these drum beats. Drugs are everywhere, we all use them, they're good for you, and other nations accept them. The suggestion is that drug use is normal, only government prohibition of them is abnormal, and it hurts our citizens to levy laws against drug use.

But the claim of normalcy is patently false. Over ninety percent of Americans do not use drugs. The overwhelming majority of children do not use drugs. Even at their most risk prone and rebellious years, seventy-five percent or more of adolescents do not use drugs. And of the millions who experimented with drugs in the 1960's and 1970's, most have succeeded in breaking away from their habits.

Unfortunately, not all have succeeded in breaking their drug habit – in this decade alone over 110,000 of our citizens have died from their drug use. Across this nation, over four million of our citizens are trapped in their addiction, many of these addicts no doubt already experiencing a life of failed health and social and economic ruin, and the remainder facing much the same unless they get help.

No, drug use is not normal. The theme of normalcy is bankrupt. Only by its oft repetition does it begin to resonate, but even then with only a small minority of Americans.

We must constantly remind ourselves that the struggle against drug abuse has not been “lost.” In fact, statistics bear out a much different reality, which is that despite alarming increases in youth usage rates in the 1990's overall drug use is down substantially since 1979. Also, while it may be true that other unhealthy substances are legal, such as tobacco and alcohol, the notion that drugs should be therefore also made legal ignores the fact that a tremendous amount of criminality is tied to drug abuse. It is therefore axiomatic that increases in overall usage would bring increases in criminality, as addicts seek to feed their cravings.

This link between increased social disorder and crime, and soaring drug usage rates is clearly demonstrated in the 1997 National Household Survey on Drug Abuse. The 1999 ONDCP National Strategy summarized the NHSDA findings on marijuana use and anti-social behavior as the following: “For youth aged twelve to seventeen, those who smoked marijuana within the past year were more than twice as likely to cut class, steal, attack people, and destroy property than were those who did not smoke marijuana.”

That marijuana spearheads increases in social pathology in youth users should come as no surprise because marijuana, despite the best efforts of the legalizers to portray it otherwise, is not a “soft” or harmless drug. It has been conclusively demonstrated to be the “most dangerous drug” in America precisely because it does serve, most particularly for young people, as an introductory drug to other types of addictions. In short, increased marijuana use by young people will translate, over time, into both substantial increases in overall drug use of cocaine, heroin, methamphetamines and others as well as the overall crime rate for the United States.

Finally, despite overwhelming evidence to the contrary, legalizers engage in what amounts to intellectual chicanery when they continually tout the benefits of smoked marijuana as “medicine.” Until medical science determines that smoked marijuana can pass muster as “medicine” in the most advanced society on the globe, with the best medical care that the world has ever seen, we should refrain from dignifying marijuana as anything more than what it is - a harmful drug which addicts invariably claim as their initiation into a life of ruin. The medical marijuana issue can only be viewed as a stalking horse for the legalization of drugs.

As Florida is concerned, my state can and will do much to overcome the bad experience it has suffered in recent years from illegal drugs. It does not intend to meet the challenge by making drugs legal. Instead, it will give to its citizens the support they have requested in educating the public as to the dangers of drugs, providing for more education, prevention, and treatment, and empowering law enforcement and the judiciary systems to deal with those who would deal in drugs. In partnership with the federal government, Florida intends to deal with the drug challenge responsibly, making our state a better place for all to live, work in, and visit.

The American people overwhelmingly reject drugs. They don’t want to see their children become addicts, even if the government should promise to subsidize their habit. In the end, I have every reason to believe that, properly informed, we as a nation will reject the bad idea that a free drug America makes for a better place to live than a drug free America. Hearings such as this are a positive step in placing information before our citizens. I thank you for the opportunity to testify.

Mr. MICA. We will withhold questions.

I would like to recognize next Mr. Ira Glasser, the executive director of the American Civil Liberties Union.

You are recognized, sir. Welcome.

Mr. GLASSER. Thank you.

I ask to have my testimony which I have delivered to the committee be submitted for the record, and then I will summarize.

Mr. MICA. Without objection, that entire statement will be made a part of the record.

Mr. GLASSER. Thank you.

Let me speak to the three named topics of this hearing, to harm reduction, to criminalization and to legalization. These terms are thrown around a lot by a lot of different people. It is not always clear what they mean. So I want you to be clear what I mean.

There are two kinds of harms associated with drugs. One set is caused by the drugs themselves. That is mostly what we have been talking about today. It is important to say, and we have not heard much of that today, that those harms vary widely, depending on the particular drug, depending on its potency, depending on its purity, depending on its dosage, depending on the circumstances and the frequency of its use.

There is no such thing as harms from drugs; there are only harms from particular drugs used in particular ways, in particular frequencies at particular dosages.

We have also not heard, but I think it is important when you are making policy, distinctions between use and abuse. We have heard just now, for example, that no parent would say, "If only drugs were legal," if they had a child who overdosed from drugs. I am the parent of four children who grew up in the middle of Manhattan. I agree with that. I would be very distraught if one of my kids had died from an overdose of drugs.

But I tell you what I would say as a parent and what I have heard many parents say when their kids are not drug abusers but maybe smoked a marijuana joint when they were 16 in the same way as they may have tried a beer. Both of them are illegal at the age of 16. But these kids were under control, they used it moderately once in a while, they did well in school, they did well in sports, and they grew up to be stable, productive kids. Those parents were not real happy about the law.

When my 15-year-old came to me, 20 years ago now, and said, "I'm smoking marijuana, what should I do about it?" I talked to him as I would have if he told me he was drinking beer. And then I told him one other thing. I said, you have two additional dangers from marijuana that you don't have from beer. One of them is you can get arrested for it, and the other is you don't know what you're getting on the street because it's totally unregulated. And it is only for those two reasons and not for any other reasons, not for any pharmacological reasons, that I was more concerned about his use of marijuana than I was about his use of beer.

Kids can be destroyed in a lot of ways. Frankly, I don't need the government's help in raising my children; and I don't want the government's intervention, particularly with the police power of the State.

I had real concerns about my kids drinking too much. But that had nothing to do with legality or illegality. It had to do with teaching children the responsible use of dangerous substances.

And it is critical when you are making policy to make distinctions, I think, between use and abuse. There are 70 million people, most of them adults, in this country who have admitted to using marijuana; and virtually all of them have done so while maintaining productive and stable lives. Most of them you wouldn't even know they had smoked marijuana.

It used to be said, 15 years ago, that every family had somebody gay in their family, only they didn't know it. That is true of marijuana use today. We hear the stories of the abuse, but we don't hear the stories of the use, we don't hear the stories of controlled use, of moderate use, of long-term use, within lives that are otherwise stable and productive.

One of the questions we have to ask ourselves is, do we want to make those people criminals out of the concern for people who are abusing drugs? Those are very important differences.

The second kind of harm is the harm associated with the law itself. Our laws, which are criminal prohibition laws for the most part, create problems, just as they did during alcohol prohibition, that the drugs themselves do not cause. Al Capone did not shoot people because he was drunk, and most drug dealers are not shooting people because they are high. There are many studies which show that. It makes sense. Everybody knows that Al Capone didn't shoot people because he was drunk. He was settling commercial disputes with weapons in the streets because that is what prohibition requires you to do because you can't settle disputes through the law.

The random, escalating violence in our streets is not caused by the drugs. It is certainly not caused by marijuana, which if anything makes people less aggressive. It is caused by making commercial transactions which we cannot prevent be settled outside the law with violence in a way that endangers all sorts of people, including innocent bystanders.

Now, criminalization and legalization. Criminalization means the attempt by society to control the availability of drugs in order to deal with drug abuse; to control the availability through criminal prohibitions with heavy penalties by interdiction and by deterring commercial transactions. That is what criminal prohibition is. That is what criminalization is.

We ought to be assessing whether criminal prohibition works, not on the basis of moral fervor about drug use and certainly not on the basis of a concern about drug abuse which criminalizes drug users who have no problem. We ought to be assessing whether, in fact, it reduces drug availability, whether, in fact, it deters commercial transactions and whether perhaps it doesn't create harms that didn't exist there before.

Legalization refers to an alternative system. I want to say this very carefully. Legalization refers to an alternative system of controlling the availability and safety of drugs. It means that you have regulations of various kinds instead of criminal prohibition.

You cannot regulate what you are trying to prohibit because, by definition, when you prohibit, you are putting it outside the law.

Regulations can range from medical prescriptions for things like Prozac and valium, and it can range from more restrictive kinds of medical prescriptions like the use of morphine over a 2-week period for pain relief in a hospital setting; and it can be regulations that are milder like those used for alcohol and tobacco.

We would never say that, because there are 15 million alcoholics in this country, we should make criminals out of people who drink a bottle of wine at night with dinner or have a scotch after work. We would never say that, and this country would never accept it. And we would not even say, even to those 15 million who are alcoholics, that the way to deter you from being alcoholics and ruining your lives and the lives of the people around you is to put you in jail and arrest you. We don't say it with alcohol, we don't say it with tobacco, so why do we say it with marijuana, for example? It has to be that there is something much worse about marijuana use than there is about alcohol use and tobacco use.

Part of the task, if you are going to really be objective and impartial about this, is to find out what exactly that is. And the science that we bring to bear on that has to be a science that is contested, that is peer reviewed and that is not the product of political conclusions drawn first with the scientific evidence marshaled to support it.

There are books you have introduced today. There are other books you ought to be introducing. I can tell you what some of them are. I have read them all.

As a nonscientist, I can tell you when you read them all, you find that the science is a lot more unsettled than we have heard here today and that, in fact, marijuana may be one of the mildest drugs and the least dangerous drugs and the least capable of abuse of all the drugs we are talking about, including those that are legal. So the question about why do you want to criminalize even heavy use users and, above all, why we want to criminalize productive users who are using it the way you use alcohol, is a heavy burden for a free society to bear. It is a burden I suggest you ought to take seriously.

One final point. The enforcement of drug laws in this country has become an engine for the restoration of Jim Crow justice. We have to talk about race when we are talking about the enforcement of drug laws. Maybe this is not inevitable and maybe it is not an inevitable consequence of prohibition, but the racially disparate sentences between crack cocaine and powdered cocaine, the racially disparate arrests for the same offense, the racial profiling that goes on in drug interdiction on our highways of which we have heard so much of recently, the racial profiling in sentencing, the disproportionate number of black and Latino people who are in prison for the same offenses in the face of everybody telling us that most drug users and most drug addicts are white. As long ago as the early 1980's, William Bennett, one of General McCaffrey's predecessors, said 80 percent of the drug addicts and drug users are white males in their 20's in the suburbs, but that isn't who we are arresting and that isn't who we are sending to jail and that isn't who we are pulling over in their cars.

The racial consequences of this experiment in criminal prohibition are stunning in this country and have also led to the dis-

enfranchisement, the post-felony disenfranchisement of 14 percent of African American men. One in three men between 20 and 29, African American men, are now under the jurisdiction of the criminal justice system, most of them for nonviolent arrests, most of them for possession.

Thirteen percent of all monthly drug users are African American, according to Federal Government statistics—but 34 percent of those arrested are African-American, 55 percent of those convicted are African-American, 74 percent of those imprisoned are African-American. That is a scandal that has to be part of the burden you bear when you look at the consequences of criminalization.

Thank you.

Mr. MICA. Thank you for your testimony.

[The prepared statement of Mr. Glasser follows:]

Testimony of Ira Glasser
Executive Director
American Civil Liberties Union

Criminal Justice, Drug Policy and Human Resources
Subcommittee

Hon. John L. Mica, Chair

June 16, 1999

Thank you for inviting me to testify today. In the June 9 edition of the Congressional Quarterly Daily Monitor, the subject of today's hearing is listed as covering the issues of "drug legalization, criminalization and harm reduction." Since these terms are often differently defined, let me begin by offering my definition, so the Subcommittee can be clear about my testimony.

I. Definition of terms

A. Harm reduction. There are two kinds of harms associated with the use of drugs. One set of harms may be caused by the drugs themselves, and varies widely, depending on the particular drug, its potency, its purity, its dosage, and the circumstances and frequency of its use. Distinctions must be made between the harms caused by heavy, compulsive use (e.g., alcoholism) and occasional, controlled use (e.g., a glass of wine each night with dinner). Distinctions must also be made between medical use (e.g., heavy dosages of morphine prescribed by doctors over a two-week period in a hospital setting or methadone prescribed daily on an outpatient basis as maintenance) and uncontrolled use (e.g., by addicts on the street using unregulated heroin and unclean needles). And distinctions must be made as well between relatively benign drugs (e.g., marijuana) and drugs with more extreme short-term effects (e.g., LSD) or more severe long-term effects (e.g., nicotine when delivered by smoking tobacco).*

The second kind of harm associated with the use of drugs is the harm caused not by the drugs themselves but by dysfunctional laws designed to control the availability of the drug. These harms include massive incarceration, much of it racially disparate, and the violation of a wide range of constitutional rights so severe that it has led one Supreme Court justice to speak of a "drug exception" to the Constitution. Dysfunctional laws have

* What exactly the short- and long-term effects of particular drugs are at particular potencies, dosages and frequencies of use is often a matter of dispute. But it is critical that such disputes be settled by impartial scientific scrutiny and not, as they often have, by ideology, politics and propaganda.

also led to reduced availability of treatment by those who desire it (e.g., methadone maintenance), as well as a number of harms created by uncontrolled and unregulated illegal markets (e.g., untaxed and exaggerated subsidies for organized criminals; street crime caused by the settling of commercial disputes with automatic weapons; unregulated dosages and impurities; unclean needles and the spread of disease, etc.).

All laws that address the issue of drugs ought to be evaluated by assessing whether or not they reduce or enhance such harms.

B. Criminalization. This term refers to the effort to control the harmful effects of drugs by making it a crime, often with heavy penalties attached, to possess, buy or sell drugs. The purpose of criminal prohibition is to sharply reduce availability of drugs by interdicting supplies and deterring commercial transactions. Any assessment of criminalization must measure the extent to which this purpose has been achieved, and the extent to which new harms have been created and sustained.

C. Legalization. This term refers to a wide variety of efforts to control the harmful effects of drugs by regulating, instead of criminally prohibiting, their sale and use. Depending on the drug, regulations may require a medical prescription (e.g., Prozac) or may limit the settings in which a prescription may be used (e.g., morphine). Other drugs may be regulated less restrictively (e.g., alcohol, tobacco). People who advocate this approach believe that the harmful effects of drugs can be better controlled by regulation; that different regulations would be appropriate for different drugs; and that Congress would be more productive if it embarked upon this path, and began the difficult process of developing a differential system for regulating the availability of drugs.

II. General principles

The American Civil Liberties Union believes, and has believed for decades, that in general the best way to control the harmful effects of drugs is with a detailed set of regulations. We believe that the use of criminal prohibitions is profoundly wrong in principle, generally ineffective in practice and has created problems that the drugs themselves were powerless to create.

Criminal prohibition is profoundly wrong in principle because the state has no business using its police powers to punish adult individuals for what they decide to do with their own minds and bodies. On the most basic level, the state has no legitimate power to send me to prison for eating too much red meat or fat-laden ice cream or for drinking a few beers or glasses of wine each day. This is true in principle even if an excess of red meat and ice cream demonstrably leads to premature heart attacks and strokes. The police power of the state is legitimately used to prevent one citizen from attacking another, and to punish him if he does; it is illegitimately used to prevent adults from managing their own bodies and minds, or to punish them when they do.

Nor does clearly excessive use warrant criminal punishment. Obesity and compulsive eating disorders, while clearly problematic and often dysfunctional, are not a

justification to put people in jail, to search them for possession of forbidden foods or to seize their property when they are caught with such foods. Even more certainly, the self-abuse of compulsive overeating by some cannot possibly justify punishing others for eating the same foods, but in moderation and without apparent ill effects.

Similarly, excessive and compulsive consumption of alcohol or tobacco does not justify imprisonment, police searches or seizures of property. And certainly the behavior of alcoholics – serious abusers of alcohol – cannot justify criminalizing moderate, recreational drinking by otherwise stable and law-abiding citizens.

No American would dispute these assertions, and, of course, we do not in fact do such things to people with serious eating disorders. We don't even do it with alcohol and tobacco, despite the well-documented ill effects of compulsive use of those drugs. Why we do it with other substances, like, for example, marijuana, and whether there is something about marijuana that justifiably causes us to depart so radically from fundamental principles, is the key question this nation needs to begin openly and fairly debating.

III. Rethinking criminalization. Congress should not avoid this question by marginalizing it, or by pretending that those who advocate individual freedom, harm reduction and control through appropriate regulations rather than criminal prohibition occupy a narrow band of the political spectrum. In fact, those who oppose or who are deeply skeptical of criminal prohibition include such notable conservative thinkers as Milton Friedman and Wm. F. Buckley, Jr. as well as liberals like Mayor Kurt Schmoke of Baltimore, experienced police chiefs like Patrick Murphy, Joseph McNamara and Nick Pastore, and a number of state and federal judges.

Nor is the principle here articulated a recently-invented one. To the contrary, it is America's obsession with criminalization that is relatively recent, beginning in 1914. The tradition of personal freedom and individual sovereignty has far older and deeper roots in Western thought. As far back as 1859, for example, the political philosopher John Stuart Mill, in his famous essay On Liberty, offered the following advice to free societies and their governments:

The object of this Essay is to assert one very simple principle... to govern absolutely the dealings of society with the individual in the way of compulsion and control... That principle is, that the sole end of which mankind are warranted... in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do so or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise or even right.

There are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him... Mankind are greater gainers by suffering each other to live as seems good to themselves, than by compelling each to live as seems good to the rest. On Liberty, at lines 335-351, 471 (1859).

There is no better example of the folly of ignoring Mill's advice than the history of America's attempts over the past 85 years to control the harmful effects of drugs by making it a crime to possess, buy or sell them. This approach began in 1914, when Congress passed the Harrison Act, and was followed by hundreds of federal and state laws, all of them to one degree or another utilizing criminal penalties to punish possession, sale and purchase of a wide variety of substances including for a period of time alcohol.

The stated purposes of such laws were to make drugs less available; to interdict supplies and to deter commercial transactions. But the laws of prohibition accomplished none of these purposes. Alcohol prohibition was abandoned as a failure over sixty years ago. But criminal prohibition of other drugs continued. Between 1914 and 1970, 55 federal laws and hundreds of state laws were passed, all of them prohibitive, all of them containing criminal penalties. Almost from the beginning, the results were disappointing and counterproductive. As early as 1926, the *Illinois Medical Journal*, characterizing the 1914 Harrison Act as a "well-meaning blunder" concluded that:

...instead of stopping the traffic, those who deal in dope now make double their money from the poor upon whom they prey. 49 Illinois Medical Journal 447 (1926).

Then years later, in 1936, August Vollmer, a former police chief and leading expert on American policing, wrote:

Stringent laws, spectacular police drives, vigorous prosecution, and imprisonment of addicts and peddlers have proved not only useless and enormously expensive as means of correcting this evil, but they are also unjustifiably and unbelievably cruel in their application to the unfortunate drug victims... Drug addiction, like prostitution and like liquor, is not a police problem; it never has been and never can be solved by policemen. It is first and last a medical problem... The Police and Modern Society (1936). At p. 117-18.

And in 1958, a comprehensive study concluded:

For the past 40 years we have been trying the mainly punitive approach: we have increased penalties, we have hounded the drug addict, and we have brought out the idea that any person who takes drugs is a most dangerous person... Our whole dealing with the problem of drug addiction for the past 40 years has been a sorry mess. Problems of Addiction and Habituation 1958). At p. 171.

By the early seventies, it was clear that the situation described by Chief Vollmer and others was unchanged: prohibition had not worked. Drugs were plentifully available on the street and a lively if illegal and often violent market was flourishing. Addicts were not being helped. Interdiction was not working. And organized crime was being fabulously enriched by the artificially inflated prices of an illegal market.

Many observers at the time concluded as Vollmer had in 1936: criminal prohibition of drugs was a mistake for the same reasons that alcohol prohibition (enacted originally at about the same time) had been a mistake. It was time to rethink criminal prohibition and go in another direction. Other, non-coercive programs had begun to show effectiveness. Methadone maintenance on a voluntary, out-patient basis, had shown promise. A study of one program showed that "the overwhelming majority of patients... after years as criminals on heroin, lead a law-abiding life on methadone maintenance." And after 5 years, the failure rate remained low. Many people began to believe that addiction could be treated medically and voluntarily.

But in New York, Governor Nelson Rockefeller concluded otherwise. Despite nearly 60 years of demonstrable failure, he decided that the trouble with criminal prohibition was that as punitive as it had been, it hadn't been punitive enough. The failures of criminal prohibition, Rockefeller argued, could be reversed by even tougher laws and a more punitive use of the state's police power. Thus was born the infamous Rockefeller drug laws, now nearly universally considered a tragic mistake. Even Laurence Rockefeller, the late Governor's brother, has recently stated so publicly, and speculated that his brother, if he were still alive, would today be admitting that mistake. Perhaps.

What is clear is that between 1973, when the Rockefeller laws were passed, and today, the use of the criminal sanction has increased exponentially. On the federal level alone, expenditures have gone up from \$1.65 billion in 1982 to \$17 billion in 1998. And billions more have been spent by the states. Incarceration has gone up from a few hundred thousand to more than 1.7 million; 85 percent of the increase in incarceration between 1985 and 1995 was due to drug convictions, according to the Bureau of Justice Statistics, the bulk of them for nonviolent crimes. Driven by stunning and unjustifiable

disparities in sentencing between crack cocaine and powder cocaine, as well as other racial disparities in how drug laws are enforced, disproportionate numbers of blacks and Latinos are filling our prisons. According to federal government statistics, only 13 percent of monthly drug users are black; but 37 percent are arrested for possession, 55 percent are convicted of possession and 74 percent are imprisoned for possession. One of every three African American men between the ages of 20-29 are now under the jurisdiction of the criminal justice system. 14 percent of African American men are permanently disenfranchised.

Three-quarters of the swollen federal drug policy budget remains devoted to law enforcement, much of it to interdiction, despite the fact that no serious student of interdiction thinks it has worked or that it can work. Federal criminalization has clogged the federal court system and, according to Chief Justice William Rehnquist, is having deleterious consequences for the administration of justice. About half of all drug arrests are for marijuana, over 80 percent of them for possession. Urine testing has become a routine predicate to holding a job in 81 percent of major U.S. firms, despite studies that show that such testing is worthless to the employer as it is degrading and intrusive to the employee. Civil asset forfeiture of property – what one historian has called a government license to steal – has become widespread, at both federal and state levels, leading Judiciary Committee Chairman Henry Hyde to introduce a bill designed to reform this abuse of power. And drug interdiction has become a pretext for stopping cars whose drivers are black and Latino, leading to an epidemic of racial profiling and the harassment of innocent people that amounts to a shocking reprise of old-style Jim Crow justice.

Our 85-year experiment with criminal prohibition of drugs, and the escalation of that experiment since 1980, has not solved the problems it was meant to solve and it has created other serious problems resulting from the excessive and unprincipled use of the government's police power.

To summarize:

- Criminalization has not made drugs less available. For example, a federal study showed that in 1975, 87 percent of young people said marijuana was "very easy" or "fairly easy" to obtain. In 1998 – after millions of arrests and an exponential increase in prison sentences – the figure was 89.6 percent.
- Although criminalization has not made drugs less available, it has assured that they would be available only under the most dangerous and violent circumstances. And most of the violence is not due to the pharmacological influence of drugs but to the

illegality of the market that is created by the law. Al Capone did not shoot people because he was drunk and drug dealers do not shoot people because they are high. They settle commercial disputes with violence in the streets because prohibition permits no other option.

- Criminalization does not deter commercial transactions; to the contrary, it enriches criminals and attracts an endless parade of new entrepreneurs due to the prospect of stunning profit margins.

- Criminalization does not help addicts. The huge amount of spending on interdiction and other law enforcement – despite August Vollmer's prophetic warning over 60 years ago – detracts from our ability to provide treatment on demand to all those who want it.

- Criminalization creates other problems not created by the drugs themselves:

-- It has eroded the Fourth Amendment creating in effect what Justice Thurgood Marshall once called "a drug exception" to the Constitution.

-- It has resulted in widespread urine testing, what Justice Antonin Scalia has called "an immolation of privacy and human dignity."

-- It has led to an unprecedented explosion of racially skewed incarceration. Despite the fact that most drug users are white, most of those arrested and imprisoned are people of color. Drug prohibition has become an engine for the restoration of Jim Crow justice.

-- It has led to the spread of AIDS, a genuine public health disaster, because of prohibition on the availability and distribution of clean needles.

-- It has violated sound medical practice by restricting the use of methadone as a prescriptive medicine and by interfering with the management of pain, wasting

syndrome and glaucoma by barring the medical use of marijuana and by resisting the scientific research that would go beyond anecdotal evidence.

-- It has swept away the right not to have your property taken without due process of law, though the extensive use of civil asset forfeiture, a practice one leading historian has called a government "license to steal."

-- It has established a pretext for racial profiling on our highways, in our airports, at our customs checkpoints and on our streets that are based not on evidence but on skin color.

Above all, criminalization has intruded the state into that zone of personal sovereignty where the state should never be allowed to go, at least not in a society that calls itself free. By failing to distinguish between users and abusers, the government has demonized all drug use without differentiation, has systematically and hysterically resisted science and has turned millions of stable and productive citizens into criminals.

The Hippocratic principle that governs medical practice is: "First, do no harm." Criminal prohibition has, since 1914, done immense harm, without achieving its stated goals.

The American Civil Liberties Union urges Congress to begin again, to initiate a serious and extensive study of drugs, their benefits and their harm, and the proper role of government in mediating such harms as may exist. We believe such an inquiry, fairly conducted, will lead to the conclusion that criminalization was a mistake, and that both freedom and safety, as well as a concern for addicts, require the abandonment of criminal prohibition and the development of a differentiated and appropriate regulatory system to control the availability of drugs.

We urge you to move in that direction.

Mr. MICA. I would like to recognize next Mr. Scott Ehlers, senior policy analyst with the Drug Policy Foundation.

Mr. EHLERS. Thank you. I have a full statement that I would like to introduce into the record.

Mr. MICA. Without objection, that will be made part of the record. Thank you.

Mr. EHLERS. Thank you.

Chairman Mica, Representative Mink and other distinguished members of the subcommittee, once again my name is Scott Ehlers, senior policy analyst for the Drug Policy Foundation.

Thank you for inviting me to testify about our Nation's drug policies. I am proud to say that the Drug Policy Foundation has been on the forefront of reform since 1986.

I am sorry to say that over the last two decades, the drug war's strain on the justice system has gone up significantly. Drug arrests are up from 580,000 in 1980 to nearly 1.6 million in 1997. The number of drug offenders in prison is 22 times larger today than in 1980. We are creating, in the words of General Barry McCaffrey, a "drug gulag."

One of those prisoners is Dorothy Gaines, a mother of three from Mobile, AL. Dorothy calls me every week to tell me how she misses her children and how she would be willing to wear an ankle bracelet for the rest of her life if she could just go home. Dorothy is serving 19 years in Federal prison on a crack cocaine conspiracy charge. No evidence of drugs were ever found in her home. She has no previous arrests. She is an upstanding, church-going citizen. There is so little evidence that the State court threw the case out. But the Federal prosecutor took it anyway.

She was convicted merely on the testimony of drug dealers who lied so they could get a reduced sentence. The kingpin is going to get out of prison 8 years before Dorothy because she didn't know anyone to snitch on.

But it is not only Dorothy serving time. So is her son Phillip who wrote the trial judge to strike a deal: "Dear Judge, would you help my mom? I don't have anyone to take care of me and my sisters. My birthday is coming up in October, and I need my mom to be here. I will cut your grass, I will wash your car every day. Just don't send my mom off. Please, please, don't send her off."

Other families are being torn apart just like Dorothy's, many of whom are in this book, "Shattered Lives," which I am sending to each of you. And if there have been other books entered into the record, I am wondering if this is a possibility as well.

Mr. MICA. Without objection, it will be noted and made part of the record.

Mr. EHLERS. Thank you.

[NOTE.—The information referred to may be found in subcommittee files.]

Mr. EHLERS. Have the mass incarcerations made drugs less available? Cocaine is half as expensive today as in 1981, and heroin is five times as pure. In 1975, 87 percent of high school seniors said it was easy to get marijuana. Today, that figure is 90.4 percent. Clearly, our Nation's current drug strategy is not achieving its intended goals.

We think there is a better way, based on the following principles and reforms.

No. 1, drug use and addiction should be treated as public health issues, not criminal justice problems. With the threat of criminal sanctions gone, many more people with substance abuse problems would seek medical assistance rather than hiding out of fear of arrest.

No. 2, prevention should address the root causes of drug use and abuse. Community development, job training programs, and after-school programs should receive more support.

No. 3, drug policy should be based on science and research, not ideology. Research shows that treatment is more cost effective than prison. Marijuana is an effective medicine, and syringe exchange reduces the spread of HIV.

No. 4, drug policy should be based on a respect for the Constitution, civil liberties and property rights. Unfortunately, Representatives Barr and Cummings aren't here. I was going to thank them for cosponsoring the Civil Asset Forfeiture Reform Act, which we are supporting, that would protect property owners.

No. 5, Federal drug policy should respect democracy and States' rights. The Federal Government should respect State initiatives that have supported drug policy reforms.

No. 6, mandatory minimums should be repealed, drug sentences reduced and alternatives to incarceration implemented. Congress should support Representative Waters in passing her H.R. 1681 which would repeal mandatory minimums for drug offenses. We also support General McCaffrey's call to reduce drug prisoners by 250,000.

No. 7, the regulation and control of currently illicit drugs must be included as one of the drug policy options that is discussed. What would these regulations look like? Would the government, doctors, or special drugstores dispense the drugs? Would all currently illicit drugs be sold in the regulated market or are some unacceptably dangerous? Would drugs be regulated over 1 year or 20 years? All of these questions have to be answered by the American public.

Why must regulation be considered? Because prohibition and the resulting black market enrich criminals and terrorists around the world, encourages the recruitment of youth to sell drugs, provides youth with easier access to drugs, corrupts government officials, and undermines the rule of law.

We must also acknowledge the potential benefits of regulating the drug market, including taking the profit out of the hands of criminals and putting it into government coffers for expanding prevention and treatment efforts.

In conclusion, there are a wide variety of drug policy innovations that would save tax dollars, protect children and improve public health, but we must first realize that police and prisons are not the solution to our social problems. As a free society, we should seriously consider all the options to determine the best drug policy for our country.

Thank you again for giving me this opportunity.

Mr. MICA. Thank you for your testimony.

[The prepared statement of Mr. Ehlers follows:]

**Statement of Scott Ehlers
Senior Policy Analyst
Drug Policy Foundation – Washington, D.C.**

**Before
Subcommittee on Criminal Justice, Drug Policy, and Human Resources**

**Hearing on
“Drug Legalization, Criminalization, and Harm Reduction”**

June 16, 1999

**The Drug Policy Foundation
4455 Connecticut Ave. NW, Suite B500
Washington, DC 20008-2328**

Chairman Mica, Rep. Mink, and other Distinguished Members of the Subcommittee:

My name is Scott Ehlers and I am the Senior Policy Analyst for the Drug Policy Foundation in Washington, D.C.

Thank you for inviting me to testify about our nation's drug policies and the growing movement to bring about drug policy reform. I am proud to say that the Drug Policy Foundation has been on the forefront of these efforts since the organization's inception in 1986.

I am sorry to say that over the last two decades, the drug-war strain on the criminal justice system has gone up significantly, from 580,900 drug arrests in 1980 to nearly 1.6 million in 1997, the highest level in our nation's history.¹ The number of drug offenders in state and federal prisons has skyrocketed from 12,475 in 1980 to 281,419 in 1997, a 2,155% increase.²

INCREASED ARRESTS, PRISONERS DO NOT REDUCE DRUG AVAILABILITY

Has the U.S. attempt to incarcerate its way out of the drug problem made drugs less available or increased their price on the street? Not at all. According to the DEA, since 1981, cocaine and heroin prices are at historically low levels today, and purity is very high.³ There has been little change in the amount of cocaine, heroin, and marijuana available for consumption today compared with 10 years ago.⁴

Disturbingly, the high number of drug arrests and prisoners has not reduced young people's access to illegal drugs. The Monitoring the Future Survey found that 87% of high school seniors said it was "easy" or "fairly easy" to get marijuana in 1975. Twenty-four years and millions of

¹ FBI, 1997 Uniform Crime Reports, p. 222; FBI, 1980 Uniform Crime Reports, p. 191.

² Bureau of Justice Statistics, *Prisoners in 1997*, August 1998, as cited in *The National Drug Control Strategy*, 1999, p. 129. Bureau of Justice Statistics, *Correctional Populations in the United States, 1992*, p. 58-9.

³ In 1981, cocaine cost \$378.70 per pure gram on the street. In 1998 it cost \$169.25. Purity has risen from 40.02% in 1981 to 71.23% in 1998. Heroin cost \$3,114.80 per pure gram in 1981 and \$1,798.80 in 1998. Heroin purity has risen from 4.69% in 1981 to 24.49% in 1998. Source: System to Retrieve Information from Drug Evidence, DEA, 1981-98.

⁴ See the 1997 NNICC Report and the 1999 National Drug Control Strategy, p. 131.

arrests later, 90.4% of seniors said the drug was easily obtained in 1998. Similarly, the National Center on Addiction and Substance Abuse found that it is much easier for high school students to buy marijuana than beer.⁵ Clearly, our nation's current drug strategy is not achieving its intended goal of increasing the price of drugs and reducing people's – especially youth's – access to them.

How many people will we have to throw in prison before we declare victory in the war on drugs? How many of the 77 million Americans who have used illegal drugs should be rounded up and sent to jail? How many schools are we willing to neglect in order to expand our prison system? How many lives and billions of dollars are we going to waste before we realize, "There has to be a better way?"

DRUG-FREE OR SIMPLY UN-FREE?

What is that better way? First, we must recognize that a drug-free society has never existed in human history, and that the current attempts to create a drug-free society will simply result in an un-free society. Will we eliminate personal privacy, cut off foreign trade, institute population-wide random drug testing, wiretap all the phones, create an army of police and informants, monitor all financial transactions, and build a prison system big enough to hold every drug user before we recognize the folly of our ways? Unfortunately, this is the path on which we are currently traveling.

MINIMIZE THE HARMS ASSOCIATED WITH DRUG USE AND DRUG POLICY

If a drug-free society cannot be created, then what can be done? We can minimize the harms associated with drug use *and* our drug policies. Unfortunately, the drug war itself creates excessive amounts of harm including: the curtailment of civil liberties through heavy-handed police tactics; the ever-expanding role of the military in domestic law enforcement; large-scale imprisonment and disenfranchisement of the citizenry, particularly minorities; a growing

⁵ "Teens Report Cigarettes and Marijuana Easier to Buy Than Beer," CESAR Fax, October 28, 1996. Adapted from the *National Survey of American Attitudes on Substance Abuse II: Teens and Their Parents*, National Center on Addiction and Substance Abuse, September 1996.

disrespect for the law and police by youth and minorities because they are being targeted for drug arrests; the rapid spread of HIV/AIDS and Hepatitis; and expanding global interventionism and militarism to fight the war on drugs.

Rather than continue down this road of self-destruction, the Drug Policy Foundation and its allies would like to offer another way to deal with drug-related problems. I urge the members of the subcommittee to study the attached documents for a detailed examination of the reforms we are suggesting. Included is a summary of the FY 2000 Appropriations Recommendations (Attachment 1) and legislative agenda (Attachment 2) of the National Coalition for Effective Drug Policies, which is made up of criminal justice, public health, civil rights, women, and youth interest groups, and for which I currently serve as coordinator. I have also included a summary of the *Effective National Drug Control Strategy*, published by the Network of Reform Groups in consultation with the National Coalition. (Attachment 3) After examining these documents, I think you will see that our suggested reforms have a broad base of support, including in Congress, where numerous pieces of legislation that would implement some of the reforms we are advocating have been introduced.

SUGGESTED REFORMS

DPF's drug policy vision is based on the following principles and reforms:

1) Drug use and addiction should be treated as public health issues, not criminal justice problems. Treatment-on-request should be made available, as required by the Anti-Drug Abuse Act of 1988.⁶ Private insurance companies should provide coverage for substance abuse treatment. Methadone maintenance should be more widely available, including through private physicians. Other maintenance therapies should be explored, including the use of buprenorphine, as Sen. Orrin Hatch is seeking in S. 324, and heroin maintenance, based on the successful programs in England and Switzerland. Drug prevention efforts should be expanded, and they should be accompanied by honest, rational dialogue, not scare tactics.

⁶ Anti-Drug Abuse Act of 1988, Sec. 2012. P.L. 100-690.

Finally, if drug use and addiction were treated as a health problem, you would have health care workers reaching out to drug users, rather than the police actively seeking out and arresting people for possessing personal quantities of drugs. With the threat of criminal sanctions gone, many more people with substance abuse problems would seek medical assistance rather than hiding out of fear of arrest and imprisonment.

2) Prevention should be expanded to include activities that address the root causes of drug use and abuse. Poverty, joblessness, hopelessness, mental illness, lack of after-school activities for youth – these are reasons many individuals turn to drugs for comfort, self-medication, and recreation. To address these root causes of drug use and abuse, community development should be promoted, job training programs should be available, the mentally ill should receive adequate medication, and youth should have more recreation and learning opportunities after school, when much drug use and crime occurs.

3) Drug policies should be based on science and research, not ideology. The evidence for reform already exists. Research and experience has shown that treatment is more cost-effective at reducing the demand for drugs than prison.⁷ The Institute of Medicine found marijuana to be an effective medicine.⁸ Seven government-funded studies have found syringe exchange to reduce the spread of HIV and not increase drug use.⁹

Treatment should be provided as an alternative to prison, medical marijuana patients should not be arrested, and syringes should be available through pharmacies or syringe exchange should be funded by the government.

⁷ Johathan P. Caulkins et al., *Mandatory Minimum Sentences: Throwing Away the Key or the Taxpayers' Money?*, Rand Corporation, 1997.

⁸ "The accumulated data indicate a potential therapeutic value for cannabinoid drugs, particularly for symptoms such as pain relief, control of nausea and vomiting, and appetite stimulation." *Marijuana and Medicine: Assessing the Science Base*, Institute of Medicine, March 1999, p. ES.4.

⁹ National Commission on AIDS, 1991; General Accounting Office, 1993; University of California, 1993; Centers for Disease Control and Prevention, 1993; National Academy of Sciences, 1995; Office of Technology Assessment, 1995; National Institutes of Health Consensus Panel, 1997.

4) Drug policies should be based on a respect for the Constitution, civil liberties, and property rights. The drug war has gutted the Fourth Amendment's protection against unreasonable searches and seizures; has allowed the government to effectively steal private property under the civil asset forfeiture laws; results in racial profiling on the highways and in airports; infringes upon financial privacy, as seen in the recently defeated Know Your Customer regulations; and is used as a justification to turn the nation's schools into virtual prisons with lockdown searches, random drug testing, and video surveillance.

We recommend that the civil asset forfeiture laws be reformed, as Rep. Hyde advocates in H.R. 1658, racial profiling should be investigated, as Rep. Conyers' H.R. 1443 would do, and financial privacy should be restored, as in Rep. Ron Paul's H.R. 518.

5) Federal drug policy should respect democracy and states' rights. The federal government should stop threatening states that have passed initiatives supporting medical marijuana and other drug policy reforms. In the District of Columbia, the federal government effectively outlawed citizens from voting on a medical marijuana initiative and operating a syringe exchange program with its own funds. If democracy is to remain intact and government innovation is to take place, states' rights must be respected. Drug policy innovations should not be treated differently from other policy innovations.

6) Mandatory minimums should be repealed, drug-related sentences reduced, and alternatives to incarceration implemented. Three Supreme Court Justices, numerous federal judges, and recently, noted criminologist John Dilulio have called for the repeal of mandatory minimums because they impose unduly harsh sentences on minor drug offenders, and result in wasteful spending for incarceration without adding to public safety.¹⁰ Mandatory minimums should be repealed, as advocated by Rep. Waters in H.R. 1681, and the Sentencing Guidelines should be allowed to do the job of determining the appropriate sentence for individual offenders. Additionally, drug-related sentences should be reduced so that the punishment fits the crime, and

¹⁰ Justices Stephen Breyer and Anthony Kennedy, and Chief Justice William Rehnquist have called for the repeal of mandatory minimums. See also John Dilulio, "Against Mandatory Minimums: Drug Sentencing Run Amok," *National Review*, May 17, 1999, p. 46.

alternatives to incarceration should be implemented to reduce costs to the taxpayers and promote rehabilitation of drug offenders.

7) The regulation and control of currently illicit drugs must be included as one of the drug policy options that is considered. If I were to define “legalization,” it would be the regulation and control of the use and sale of currently illicit drugs. Would the government, doctors, pharmacies or special drug stores dispense the drugs? Would all currently illicit drugs be sold in the regulated market, or would some be deemed to be unacceptably dangerous and remain illegal? Would there be restrictions on the quantity of drugs sold to buyers? Would drugs be legalized over one year, five years, or twenty years? All of these questions would have to be answered by the American public and federal, state, and local governments. One thing we do know right now is that it would remain illegal for minors to use and buy drugs, for adults to give or sell drugs to minors, and for anyone to drive or endanger others while under the influence of drugs.

Why must regulation be considered? Because prohibition and the resulting black market enriches criminals and terrorists around the world, results in gang warfare over the control of drug markets, encourages the recruitment of youth to sell drugs, provides youth with easier access to drugs, corrupts government officials, destabilizes governments, and undermines the rule of law. Drugs that are distributed in the black market are more potent than those available in a regulated market, and they are of unknown potency and quality, resulting in increased overdoses and deaths.

If the debate about our nation’s drug policies is to be honest, open, and fully informed, then the problems created by drug prohibition must be recognized. We must also acknowledge the potential benefits of regulating the drug market, including eliminating drug trade-related violence, eliminating the recruitment of youth into the drug trade, reduced access to drugs by children, reduced drug enforcement costs, availability of less potent drugs of known quality, and the use of significant tax revenues from drug sales for prevention and treatment efforts.

CONCLUSIONS

In conclusion, there are a wide variety of drug policy innovations that would save tax dollars, save lives, protect children, and improve public safety, but politicians must first realize that police and prisons are not the solution for all our social problems. As a free society, we should be searching for ways to reduce the number of police and prisoners, not increase them.

As a free society we should also embrace an honest and open discussion about drug policy options. Unless we seriously consider all of the options, not just the status quo, we will not be able to determine what is the best policy for our country.

Thank you for giving me this opportunity to discuss these very important issues with today. I hope this hearing will serve as the beginning of a more open debate on drug policy in Congress and the rest of the country.

Effective Drug Control Budget

FY 2000 Appropriations Recommendation

**National Coalition for Effective Drug Policies
May 1999**

Organizations Endorsing the Effective Drug Control Budget*

Afrikan American Institute for Policy Studies and Planning
 AIDS Policy Center for Children, Youth and Families
 American Civil Liberties Union
 American College of Nurse Midwives
 American Medical Student Association
 American Public Health Association
 Association of Reproductive Health Professionals
 Campaign for Effective Crime Policy
 Center for Women Policy Studies
 Common Sense for Drug Policy
 Correctional Association of New York
 Drug Reform Coordination Network
 DrugSense
 Drug Policy Forum of Hawaii
 Drug Policy Forum of Texas
 Drug Policy Foundation
 Drug Policy Reform Group of Minnesota
 Family Council on Drug Awareness
 Family Watch
 Efficacy
 Federation of Families for Children's Mental Health
 General Federation of Women's Clubs
 Harm Reduction Coalition
 Human Rights and the Drug War
 Institute for Policy Studies
 Justice Policy Institute
 Juvenile Law Center
 The Lindesmith Center
 Marijuana Policy Project
 Mothers Against Misuse and Abuse
 Multidisciplinary Association for Psychedelic Studies
 National Alliance of Methadone Advocates
 National Association of Nurse Practitioners in Women's Health
 National Association of People with AIDS
 National Association for Public Health Policy, Council on Illicit Drugs
 National Association of School Psychologists
 NAACP
 National Black Women's Health Project
 National Center on Institutions and Alternatives
 National Latina Institute for Reproductive Health
 National Organization for the Reform of Marijuana Laws
 National Organization for Women Foundation
 New Mexico Drug Policy Foundation
 North American Syringe Exchange Network
 November Coalition
 Patients Out of Time
 Prisoner's Legal Services of New York
 Research and Policy Reform Center
 Service Employees International Union, AFL-CIO
 St. Ann's Corner of Harm Reduction
 Unitarian Universalist Association
 Volunteers of America
 Whitman Walker Clinic
 Women's Alliance for Theology, Ethics and Ritual
 YWCA of the USA

National Coalition for Effective Drug Policies

Effective Drug Control Budget

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 202-624-3170

FY 2000 Appropriations Recommendation Summary

The National Coalition for Effective Drug Policies, a network of organizations seeking the development and implementation of national policies that effectively address drug use and drug abuse, makes the following recommendations for expenditures on drug policy:

- increase funding for after-school programs;
- provide sufficient funds to make treatment on request a reality within the next three years;
- fund treatment and rehabilitation services for special needs groups (youth, women, families);
- adequate funds to satisfy the needs for prevention of AIDS and Hepatitis C, including funds for syringe exchange programs;
- resources to examine the racially disproportionate impact of drug enforcement;
- resources to examine the effects of prosecution of pregnant women;
- resources to prevent juvenile delinquency;
- fund for alternatives to incarceration for non-violent offenders;
- resources for honest drug education; and
- funds to evaluate alternative drug control strategies.

NCEDP is urging that law enforcement and interdiction budgets be held at current levels until they are evaluated and shown to be effective.

April 30, 1999

Honorable Ted Stevens
Chairman
Committee on Appropriations
United States Senate
Washington, DC 20510-2203

Honorable Bill Young
Chairman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Senator Stevens and Representative Young:

The National Coalition for Effective Drug Policies is a coalition of national organizations dedicated to the development and implementation of federal policies that effectively address drug use and drug abuse. NCEDP is a recently formed coalition of health, religious, women's, civil rights, professional, and drug policy reform advocates who support federal funding priorities that emphasize public health approaches to drug use. We believe that two out of every three drug control dollars should be spent on prevention and rehabilitation. By making this change in budget emphasis, the United States will be able to provide adequate funding for programs that work.

We write to you today regarding the Fiscal Year 2000 budget appropriations. Enclosed is the NCEDP: Effective Drug Control Budget FY 2000 Appropriations Recommendations. In an effort to effectively address the harms of drug abuse and the risk of drug use, NCEDP recommends the following priorities and federal appropriations for FY 2000:

- Provide sufficient funding to community-based organizations and schools for after school programs and alternative activity programs to meet the needs of America's youth within the next five years. Alternative activity programs have been shown to be effective in preventing adolescent drug abuse.
- Provide sufficient funding to make treatment on request a reality within the next three years. Treatment has been proven to be the most cost-effective way of reducing the drug market and problems associated with drug abuse.
- Provide sufficient funding to stem the health emergencies of HIV/AIDS and Hepatitis C. The engine for these epidemics is rooted in the sharing of contaminated syringes. These epidemics do not only threaten drug users they threaten all Americans.
- Evaluate current drug enforcement spending to ensure the most effective use of resources and provide sufficient funding for alternatives to incarceration for non-violent, low-level drug offenders. This will keep families together and people in their communities. In addition to being less expensive than incarceration such programs are more effective as offenders can be developed into contributing members of American society.
- Undertake an examination of current drug policies to assess its impact and develop alternatives where necessary. By any objective measure, US drug control policies are

failing to prevent the use or significantly reduce the supply of controlled substances. However, there is mounting evidence that the "war on drugs" is undermining constitutional protections and having a disproportionately negative impact on African Americans, the poor, women, and other racial and ethnic minorities.

- Hold funding for international and domestic drug law enforcement to current levels until their effectiveness can be demonstrated. These programs have seen massive increases in funding over the last two decades without any evidence of success.
- Establish a blue-ribbon commission to conduct an objective review of the evidence regarding the impact of current federal drug policies and the availability and viability of alternative approaches to address illicit drug use.

Drugs are more available, less expensive and more potent after two decades of intense law enforcement. This failure is not because of the failure of law enforcement to do its job – we have seen record seizures, arrests and incarceration – but rather due to a failed strategy. It is imperative that the racist effects of law enforcement strategies are eliminated and methods developed to remove the racially disproportionate impact before these programs are expanded.

Problems associated with drugs have worsened in recent years. The facts indicate that our current approach to drugs has failed to significantly reduce either the demand or the availability of drugs. NCEDP is committed to lessening the harms to our society of drug abuse and the risk to individuals of drug use. We would be pleased to provide a delegation of our members to discuss this matter with you.

We also look forward to your written response to our proposals. Please respond to either of the national Chairs of NCEDP: Ms. Rachel King, Legislative Counsel, American Civil Liberties Union, 122 Maryland Ave., SE, Washington, DC 20002 (202) 544-1681 or Mr. Kevin B. Zeese, President, Common Sense for Drug Policy, 3619 Tallwood Terrace, Falls Church, VA 22041 (703) 354-5694.

cc:

Members Senate Appropriations Committee
Members House Appropriations Committee

NATIONAL COALITION FOR EFFECTIVE DRUG POLICIES

Legislative Agenda

1) Protect Privacy and Property Rights

- * (a) Enact Civil Asset Forfeiture Reform
see H.R. 1658 (Hyde)

- (b) Block Implementation of "Know Your Customer" Banking Regulations
see H.R. 516 (Paul); S. 403 (Allard); or H.R. 518 (Paul)

2) Adopt Sensible Sentencing Policies

- * (a) Repeal crack cocaine disparity in mandatory sentencing
see H.R. 939 (Rangel)

- (b) Retroactive application of the 1994 Mandatory Minimum Safety Valve
see H.R. 913 (B. Frank)

- (c) Repeal drug-related mandatory minimum sentences
see H.R. 1681 (Waters)

- (d) Develop alternatives to incarceration for minor drug offenders

3) Restore Civil Rights

- * (a) Restore financial aid eligibility to students convicted of a drug offense
see H.R. 1053 (B. Frank)

- * (b) Determine the extent to which racial profiling is being used by police in traffic stops
see H.R. 1443 (Conyers); S. 821 (Lautenberg)

- (c) Restore the right to vote for felons upon release from prison
see H.R. 906 (Conyers)

- (d) Restore eligibility for basic services and benefits to this country's poorest, most disadvantaged persons (and their families) who are struggling to overcome drug addiction. End government discrimination against drug offenders and users in:

- Public housing programs
- Temporary Assistance for Needy Families (TANF)
- Supplemental Security Income (SSI)
- Immigration laws

- (e) Ensure low income pregnant women's access to prenatal care, health and support services, and drug treatment. End the criminal prosecution and civil rights violations of pregnant women who use alcohol and drugs.

Steering Committee
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4) Approve Marijuana to be Used as a Prescription Medicine

**see H.R. 912 (B. Frank)*

5) Implement the Federal Funding of Needle Exchange Programs

see H.R. 2212 in 105th Congress (Cummings)

6) Expand Drug Treatment

**(a) Allow Medicaid to cover alcohol and drug treatment*

see S. 147 in 105th Congress (Daschle)

**(b) Require private health insurance plans to cover substance abuse treatment*

(c) Allow general practioners to provide maintenance therapies

see S. 324 (Hatch)

7) Reform International Anti-Drug Efforts

**(a) Demilitarize anti-drug efforts in Latin America and along the U.S./Mexico border*

- oppose increased funding of military anti-drug efforts in S. 5, the Drug Free Century Act*

- enforce Leahy Amendment requiring Latin American anti-drug efforts paid for with U.S. funds respects human rights*

(b) End the certification process

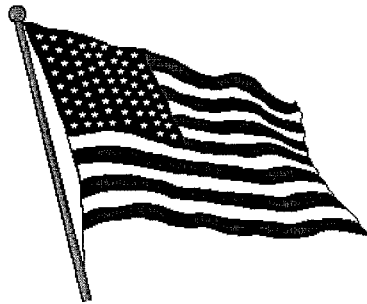
see Dodd/McCain Certification and Drug Trafficking Amendment to the Foreign Operations, Export Financing, and Related Programs 1998 Appropriations bill, rejected on July 16, 1997; see also S. 596 (Boxer)

(c) Reduce the environmental impact of drug eradication efforts in Latin America

8) Establish an Expert Commission to Study America's Current Drug Control Strategy

see H.R. 1345 in 105th Congress (Cummings)

THE
EFFECTIVE



NATIONAL DRUG
CONTROL STRATEGY
1999

NETWORK OF REFORM GROUPS

The Effective National Drug Control Strategy was prepared by the
NETWORK OF REFORM GROUPS* in consultation with the
NATIONAL COALITION FOR EFFECTIVE DRUG POLICIES*

Network of Reform Groups

Common Sense for Drug Policy
Falls Church, VA

The Council on Illicit Drugs
Washington, D.C.

Drug Policy Forum of Hawaii
Honolulu, HI

Drug Policy Forum of Texas
Houston, TX

Drug Policy Foundation of New
Mexico, Albuquerque, NM

Drug Policy Reform Group
of Minnesota, St. Paul, MN

Drug Reform Coordination
Network, Washington, D.C.

DrugSense
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Efficacy
Hartford, CT

Family Council on Drug Awareness
El Cerrito, CA

Family Watch
Washington, D.C.

Floridians for Medical Rights
Miami, FL

Forfeiture Endangers American
Rights, Washington, D.C.

Human Rights and the Drug War
El Cerrito, CA

Marijuana Policy Project
Washington, D.C.

Mothers Against Misuse and Abuse
Mosier, OR

Multi-Disciplinary Association for
Psychedelic Studies, Charlotte, NC

National Alliance of Methadone
Advocates, New York, NY

National Organization for the
Reform of Marijuana Laws
Washington, DC

The November Coalition
Colville, WA

The Rights Organization
Humboldt County, CA

ReconSIDer Forum on Drug Policy
Syracuse, NY

Virginians Against Drug Violence
Crewe, VA

Written by:

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Eric Sterling, Criminal Justice Policy Foundation
Julie Stewart, Families Against Mandatory Minimums
Kathleen Stoll, Center for Women Policy Studies
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Sanho Tree, Institute for Policy Studies
Joycelyn Woods, National Alliance of Methadone
Advocates
Kendra Wright, Family Watch
Jason Ziedenberg, Justice Policy Institute of the Center on
Juvenile and Criminal Justice

For more information on the *Effective National Drug Control Strategy* contact Common
Sense for Drug Policy at 703-354-5694, 703-354-5695(fax) or info@csdp.org

*Members with narrow missions only sign onto those portions relevant to their mission.

The *Effective* National Drug Control Strategy

This is a four page summary of *The Effective National Drug Control Strategy* - the first comprehensive alternative to the "War on Drugs." *The Effective National Drug Control Strategy* was written by the Network of Reform Groups, a federation of two dozen organizations representing 100,000 members. The goal of *The Effective Strategy* is to make a safer and healthier America for our children, reduce the spread of disease related to drug use, lower crime rates related to the illegal drug market and end the racial injustice associated with current drug policy. Information on how to receive a full copy is available at the end of this summary.

The need for a new model of drug control

The current model of drug control relies primarily on law enforcement to seize drugs and imprison drug offenders. While these efforts have produced large numbers of arrests, incarcerations and seizures, drug overdose deaths have increased 540% since 1980 and drug-related problems have worsened:¹ emergency room visits, adolescent drug use, and the spread of disease (particularly AIDS and hepatitis) have also risen substantially and drug-related crime continues at high levels. In an effort to minimize drug-related crime, illness and death, *The Effective National Drug Control Strategy* advocates a policy which emphasizes public health approaches to drug control.

How many people must we incarcerate for current drug policy to work?

The drug war has succeeded in arresting and incarcerating large numbers of people. There are over 1.7 million Americans behind bars. As of June 1996, 5.5 million Americans were under some form of control by the justice system. This translates into 1 out of every 35 adults in the nation.² According to the Department of Justice, 85% of the increase in the federal prison population from 1985 to 1995 was due to drug convictions.³ Figure 1 illustrates the massive expansion of drug offenders in the jail and prison population, which has increased nearly 12-fold from 1980 to 1995, and a strikingly similar rise in drug overdose deaths over the same period. The graph cannot express the financial and psychological damage endured by the children and spouses of those incarcerated. Nor does it express the damage that certain communities and racial groups experience. For example, black males born today have a nearly one in three chance of going to prison.⁴

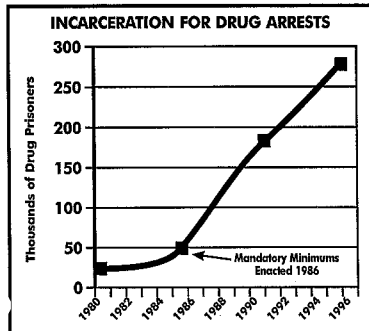


Figure 1 Sources: Bureau of Justice Statistics. *Trends in US Correctional Populations, 1995*. US Department of Justice; National Institute on Drug Abuse.

Does the U.S. drug strategy protect children from drugs?

Current government policy seeks to prevent children from gaining access to illegal substances. Since 1975, the federal government has been asking high school seniors how easy it is for them to obtain marijuana. Illustrated by Figure 2 on the following page, adolescents' access to marijuana is virtually unchanged by the drug war. In 1975, 87% of youths said it was "very easy" or "fairly easy" to obtain marijuana. Twenty-three years and millions of arrests later, 89.6% said it was easily obtained. Has the drug war succeeded in reducing adolescents' access to drugs?

¹ Decker, Dr. Ernest. (1998, Jan./Feb.). Public Health Reports, "Drug Prohibition and Public Health." U.S. Public Health Service. Vol. 114.

² Bureau of Justice Statistics. (1997, August 14). Nation's probation and parole population reached almost 3.9 million last year. Press Release, Washington, DC: Department of Justice.

³ Bureau of Justice Statistics. Prisoners in 1996. Washington, DC: Department of Justice.

⁴ Bureau of Justice Statistics. (1997, March). Lifetime Likelihood of Going to State or Federal Prison. p. 1. Washington, DC: Department of Justice.

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The Effective National Drug Control Strategy

The Drug War does not protect our youth

Since 1992, federal surveys show there has been a rise in adolescent drug use. In particular cocaine and heroin use have been increasing among youth. Since 1991 twice as many 8th grade students report using heroin and three times as many report using crack. This has coincided with record spending, record arrests and record incarceration rates. The drug war has escalated for decades, but has not resulted in less adolescent drug use.

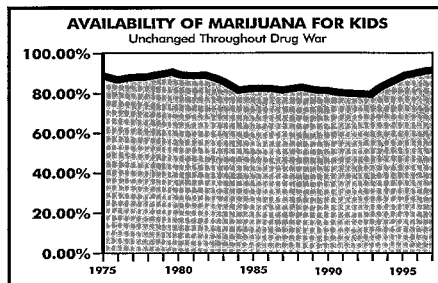


Figure 2 Percent of high school seniors who say marijuana is 'very easy' or 'fairly easy' to obtain. Source: NIDA. (1997). *Monitoring the Future Survey*, Table 12. "Long-term trends in perceived availability of drugs, twelfth graders."

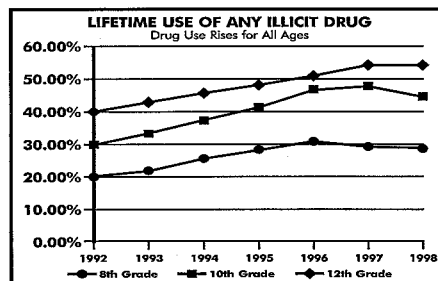


Figure 3 Source: NIDA. (1998) *The Monitoring the Future Survey 1998*. Washington, DC: Department of Health and Human Services.

risen greatly. The price of cocaine has similarly dropped from \$275.12 per gram in 1981 to \$94.52 in 1996.

Despite massive investments in border patrols, overseas crop eradication efforts, Department of Defense involvement and arrests of drug smugglers and drug dealers, the drug war has not reduced the supply of drugs nor made them more costly to obtain.

The market prices for illegal drugs follow the same laws of supply and demand that apply to all commodities. The drug war created an artificially high commodity price, and these huge profit margins encouraged more drug producers to enter the market. Greater production created economies of scale with lower production costs. Since then, lower production lower production costs have allowed drug cartels to earn the same high profit margins with lower retail prices. The cartels accommodate for interdiction efforts

Drug crimes receive some of the most severe criminal sanctions in our legal system. Based on federal surveys of adolescent drug use and by definition of state and federal law, more than 50% of all high school seniors are drug criminals who should be imprisoned. Is this a realistic or appropriate approach to controlling juvenile drug use? If not, then why should only some be arrested? How do we determine who gets prison sentences and who does not?

The current model of youth drug control essentially relies on the random chance of arrest, coupled with an increasing use of locker searches drug-sniffing dogs, and "just say no" television ads to reduce adolescent drug use. These are unsophisticated approaches to youth drug use that are not based on strategies proven to work.

Does the current drug control strategy reduce the supply of drugs and raise their price?

The indicators of a successful supply-reduction effort are rising drug prices and decreasing drug purity levels.⁵ Using data supplied by the ONDCP (Office of National Drug Control Policy), it is clear that the price of heroin has instead dropped significantly over time, while its production has

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⁵ ONDCP. (1998). *Performance Measures of Effectiveness*. Washington, DC: p. 13.

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The Effective National Drug Control Strategy

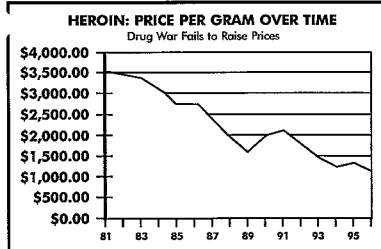


Figure 4 Source: ONDCP. 1998 *National Drug Control Strategy*. Table 20.

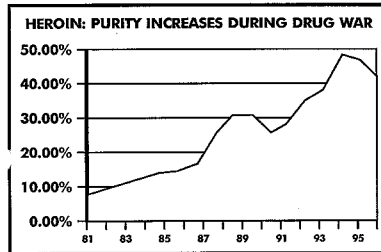


Figure 5 Source: ONDCP. 1998 *National Drug Control Strategy*. Table 20.

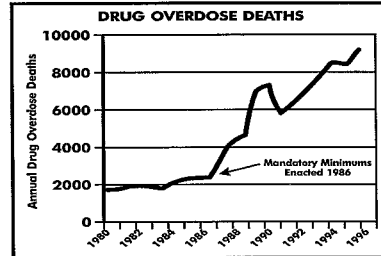


Figure 6 Source: Substance Abuse and Mental Health Services Administration. Data from the Drug Abuse Warning Network (DAWN): Annual Medical Examiner Data [1980-1996].

⁶ Associated Press. (1997, June 26). "U.N. estimates drug business equal to eight percent of world trade."

⁷ Day, Dawn. Health Emergency 1999: The Spread of Drug-Related AIDS and Other Deadly Diseases Among African-Americans and Latinos. (1998).

The Dogwood Center, p. 5.

⁸ Day, Dawn. (1998). pp. 1, 4.

by over-producing their commodity to account for the losses. Since a kilogram of raw opium has been reported to sell for \$90 in Pakistan, but is worth \$290,000 in the United States, law enforcement seizures at our borders have very little impact on cartel operations or profitability.⁶

Does the current strategy protect public health?

Easy availability, increased purity and lowered prices have resulted in high levels of overdose deaths and drug-related hospital emergency room visits. Figure 6 illustrates the steady rise in overdose deaths as recorded by the Drug Abuse Warning Network (DAWN).

Even more alarming has been the devastating expansion of the HIV and Hepatitis C epidemics due to the prohibition on needle possession. Sharing of needles is an engine for the spread of HIV and Hepatitis C. Each day 33 more people are infected with HIV due to injection drug use.⁷ The epidemics have been particularly onerous on African-American and Latino communities. By the end of 1997, it was estimated that more than 110,000 African-Americans and 55,000 Latinos were living with injection-related AIDS or had already died from it.⁸ These facts make it hard to avoid the conclusion that the current model of drug control: 1) does not reduce adolescent drug use; 2) does not reduce the supply of drugs; 3) does not reduce the harm caused by drugs.

It is time to develop a drug strategy that works.

Since we are failing to reduce the supply and use of drugs, while incarcerating record numbers of drug offenders, we need to accept that criminal laws cannot effectively solve the complex issue of drug use. Indeed, there is mounting evidence that the extreme criminal sanctions we employ today may actually worsen some of the problems of drug abuse. *The Effective National Drug Control Strategy* provides a detailed alternative model of drug control based on sound research and empirical evidence, and was developed by a wide range of professional associations. *The Effective Strategy* emphasizes public health approaches, investment in our children and confronting the underlying economic and social problems, which are the root causes of drug abuse.

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The *Effective* National Drug Control Strategy

The *Effective Strategy* seeks to balance law enforcement, treatment and prevention efforts. As this strategy takes effect we expect that law enforcement's role in drug control can be reduced further, to solely focusing on major international drug smugglers - instead of its current emphasis on arresting individual drug users. We urge that five years after implementation, the policy be evaluated and a longer term strategy be developed.

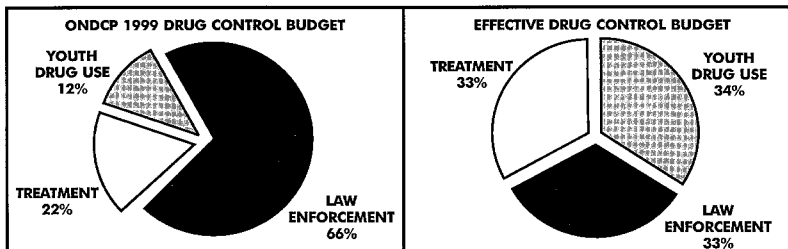


Figure 7 ONDCP National Drug Control Budget vs. *The Effective Drug Control Budget*.

Without increasing the federal drug control budget (currently \$17.9 billion) by a single dime, we can adequately fund public health based drug control programs which are friendly to family values and are proven to work. These include:

- After school programs, mentor programs and activities for youth which have been shown to be the most effective way to prevent adolescent drug use;
- Treatment on request, as has been mandated by Federal law since 1988, so drug-dependent persons who want to stop their drug use can do so;
- Rehabilitation programs including skills building, job training and education programs;
- Treatment and rehabilitation designed for the specific needs of women, and easing access to Temporary Assistance to Needy Families and education benefits to women with substance abuse problems;
- Disease prevention programs emphasizing education, syringe exchange and other public health strategies;
- Alternatives to incarceration so that families can be kept together and people with drug problems can develop successful lives;
- Educational activities from K through college so we keep kids in school and provide opportunities for the future rather than investing in prisons.

By de-emphasizing law enforcement we can:

- Dramatically reduce the prison population;
- End racial disparities in drug arrests and imprisonment;
- Restore civil liberties eroded as a result of the drug war;
- End mandatory sentencing and restore judicial authority;
- Demilitarize law enforcement activities;
- Restore due process to property forfeiture;
- Reduce the burdens placed on our justice system by drug enforcement;

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View the entire report at: www.csdp.org

If you would like more information or a hard copy of *The Effective Strategy* contact info@csdp.org or call 703-354-5694 or Fax 703-354-5695.

Common Sense for Drug Policy, Kevin B. Zeese, President

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Mr. MICA. I would like to recognize Mr. Robert Maginnis, senior director of the Family Research Council.

You are recognized. Welcome, sir.

Mr. MAGINNIS. Thank you, Mr. Chairman, members of the committee.

Sir, I would ask to have my testimony submitted for the record. I also have five exhibits, actually No.'s 1 through 5 and No. 7, that I would like to show as I go through my testimony, if I may.

Mr. MICA. Thank you. Without objection, we will make that part of the record, and we would be glad to show your displays here.

Mr. MAGINNIS. Legalizers will promote myths, and we will probably hear some today. The truth is that drug legalization, as the DEA indicated, will lead to more crime and violence, significantly higher social costs and ruin millions of lives from addiction and use. These tragic results promise severe consequences for the nonusing public as well.

I also want to dismiss the spin given to the so-called quasi-legalization, "successes" like those in the Netherlands and Switzerland.

There are five slides here I would like to show to indicate I visited these countries numerous times and have seen their drug problems. I have discussed their bankrupt policies with government officials, drug treatment specialists, addicts and their families.

Now, they took these, the first five, if you can just run through those, please, they took a very public embarrassment to Switzerland, and these are only in Switzerland and not the Netherlands today, and they put this underground, basically. They hid it in shooting galleries, they hid it in heroin giveaway clinics, they hid it across the country. It still exists. It is just that it is not in a big forum right in the middle of Platzpitz Park in downtown Zurich or in Bern or some other countries, but they continue to have a real problem.

I think it is interesting and worthwhile, noting that slide No. 7, if she would show that. You can't quite read this, but, basically, it is an advertisement, a giant billboard in one of the Swiss cities that says, Bill Clinton smoked pot, and he didn't become a junkie. The message is clear. They are taking our cultural, our political icons in this country and using it to promote their liberal drug policy. Very disturbing.

Unfortunately, I have seen much the same in my two visits here recently in the Netherlands.

I will continue with my statement, sir.

Unfortunately, in this country, I see a growing tolerance for liberal drug policies such as medical use of marijuana and free needles for junkies. These radical ideas are seldom about compassion but mostly part of the legalization slippery slope. The recent Institute of Medicine report makes mincemeat of smoked pot as medicine, and recent peer reviewed medical journal studies show the hollow ground under needle pushers.

Two ideas are key. First, drug intolerance does work; and, second, Americans and especially those harmed by drug use understand that legalization is a deadly path.

Our military's experience shows that drug intolerance does work. In 1980, 37 percent of our service members reported using drugs.

Some units were nearly incapable of doing their mission because of drug and alcohol abuse. Today, illegal use in the military stands at 2.7 percent. That is a victory for our country.

Now, the armed forces won the drug use war by enforcing tough rules. Drug use came to mean either immediate discharge or a single chance at treatment. Frequent and random drug testing radically cut casual use as well.

I was an Army company commander in Europe during the early 1980's when the military cracked down on drug use. As a commander, I supervised testing, ordered soldiers to treatment and disciplined or discharged others. We cleaned the ranks. Today's military remains just as tough on drugs and is much better as a result.

The military's tough antidrug program offers valuable lessons for American society. First, aggressive use of testing ought to be employed where legal. Second, promotion of intolerance with stiff sanctions must become the rule. Third, treatment with the threat of sanctions like today's drug courts works. And, most importantly, parents, friends and local leaders must stay involved.

Americans approve of tough drug laws and oppose legalization.

I would point out our survey that we do every year. We found that when told about the high potency of modern marijuana, 7 of 10 voters oppose legalization. Nearly two-thirds of voters believe that legalizing cocaine and heroin would increase violent crime.

Legalization would radically increase use, which would impact the innocent as well. Users are known to terrorize their families and neighbors with violent acts or to steal from them. Too often, where children are involved with a drug-using adult, abuse and neglect are common. Welfare recipients on drugs stay on the public dole much longer. In some cities like Baltimore, most felony suspects test positive for illicit drugs.

The bankrupt notion that this country would legalize drugs is especially disconcerting to the average citizen who doesn't want to make drugs easier for kids to get. This strongly held view is supported by a May 1999 Gallup public opinion survey that found that 9 of every 10 Americans believe increased violence is linked with drug and alcohol use by school age children.

In conclusion, I urge you to reject the mythology of legalizers. The use of drugs like marijuana, cocaine, methamphetamine and heroin cause widespread damage and death. Making these substances legal would pave this country's path to social catastrophe. Thank you.

Mr. MICA. Thank you for your testimony.

[The prepared statement of Mr. Maginnis follows:]



Testimony before
The Subcommittee on Criminal Justice, Drug Policy, and Human Resources
United States House of Representatives
June 16, 1999

“The Pros and Cons of Drug Legalization, Decriminalization and Harm Reduction”

by
Robert L. Maginnis
Senior Director, National Security & Foreign Affairs
Family Research Council
Washington, D.C.

Mr. Chairman, Members of the Subcommittee, Ladies and Gentlemen:

I appreciate the committee’s invitation to participate in this panel.

I strongly oppose the legalization of drugs like marijuana, cocaine and heroin.

Legalizers will promote myths. The truth is that drug legalization will lead to more crime and violence, significantly higher social costs and ruin millions of lives from addiction and use. These tragic results promise severe consequences for the non-using public as well. I also dismiss the spin given to the so-called quasi-legalization “successes” like those in The Netherlands and Switzerland. I have visited these countries numerous times and have seen their drug problems. I have discussed their bankrupt policies with government officials, drug treatment specialists, addicts and their families.

Unfortunately, in this country, I see a growing societal tolerance for liberal drug policies such as the “medical” use of marijuana and free needles for junkies. These radical ideas are seldom about compassion but mostly part of the legalization slippery slope. The recent Institute of Medicine report makes mincemeat of smoked pot as “medicine,” and recent peer reviewed medical journal studies show the hollow ground under needle pushers.

Two ideas are key. First, drug intolerance does work and secondly, Americans, and especially those harmed by drug use, understand that legalization is a deadly path.

Our military’s experience shows that drug intolerance works. In 1980, 36.7 percent of our service members reported using drugs. Some units were nearly incapable of doing their mission

Family Research Council

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because of drug and alcohol use. Today, illegal drug use in the military stands at 2.7 percent. That's a victory for the country.

The armed forces won the drug use war by enforcing tough rules. Drug use came to mean either immediate discharge or a single chance at treatment. Frequent and random drug testing radically cut casual use as well.

I was an Army company commander in Europe during the early 1980s when the military cracked down on drug use. As a commander, I supervised testing, ordered soldiers to treatment and disciplined or discharged others. We cleaned the ranks. Today's military remains just as tough on drugs and is much better as a result.

The military's tough anti-drug program offers valuable lessons for America's society. First, aggressive use of testing ought to be employed where legal. Second, promotion of intolerance with stiff sanctions must become the rule. Third, treatment with the threat of sanctions like today's drug courts works. Most importantly, parents, friends and local leaders must stay involved.

Americans approve of tough drug laws and oppose legalization of drugs like marijuana, cocaine and heroin. A 1999 national voter survey commissioned by the Family Research Council found:

- When told about the high potency of some modern marijuana, 7 of 10 voters oppose legalization.
- Nearly two-thirds of voters believe that legalizing cocaine and heroin would increase violent crime.

Legalization would radically increase use, which will impact the innocent as well. Users are known to terrorize their families and neighbors with violent acts or steal from them. Too often, where children are involved with a drug-using adult, abuse and neglect are common. Welfare recipients on drugs stay on the public dole much longer. In some cities like Baltimore, Maryland, most felony suspects test positive for illicit drugs. Easier access to drugs will make these problems worse.

The bankrupt notion that this country would legalize drugs is especially disconcerting to the average citizen who doesn't want to make drug use easier for kids. This strongly held view is supported by a May 1999 Gallup public opinion survey that found that nine of every ten Americans believe increased violence is linked with drug and alcohol use among school-aged youth.

Parents of adolescents are especially opposed to legalization. A Colorado mother now caring for her 37-year-old son, who ruined his life as an adolescent drug user, said, "[a]ll family members are abused by the drug user. This can be physical, verbal or mental abuse. The family's world stops and everything is put on hold and centered around the drug user." She opposes making drugs easier to obtain because it will result in many more ruined lives.

A Chicago attorney wrestled with his high school son's long-term marijuana addiction. The attorney explained, "The marijuana was so readily available and used, that [his son] felt it was perfectly okay to use and that we [his parents] were way off base in our objection to his use." Today the boy is drug-free, but the father explains that his son "is convinced that he would have progressed to other drugs" had he not found help.

This father argues that "legalization of marijuana or other drugs would eliminate a powerful argument that we have as parents stating that it is illegal and that one is subject to criminal liability for possession or use. ... We as parents need a strong message, backed up by society, our schools, churches, government, and each other – that marijuana is harmful and emotionally addictive."

An Indiana woman recently expressed her opposition to legalization. Her husband, a carpenter, saw a fellow worker who is an addict nail his foot to the floor and didn't know it until he found he couldn't move. She asks, "Do we really want it legal for surgeons, pilots, school bus drivers, heavy equipment operators, train engineers and military leaders to be flying high without a plane? Most in the real world say 'no.'"

I urge you to reject the mythology of legalizers. The use of drugs like marijuana, cocaine, methamphetamine, and heroin cause widespread damage and death. Making these substances legal would pave this country's path to social catastrophe.



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LEGALIZATION OF DRUGS: THE MYTHS AND THE FACTS

by
Robert L. Maginnis

Despite data which strongly supports the continuation of effective drug abuse prevention, treatment and enforcement programs, some prominent Americans support legalizing illicit drugs. For example:

- George Shultz, former President Reagan's Secretary of State, says that "Legalization would destroy dealer profits and remove their incentive to get young people addicted."¹
- Nobel laureate in economics Milton Friedman says that the criminalization of certain drugs undermines respect for the law and creates "a decadent moral climate." He states that legalizing drugs like marijuana and cocaine would "thus strike a double blow; reduce crime activity directly, and at the same time increase the efficacy of law enforcement and crime prevention."²
- U.S. Federal District Judge Robert Sweet says the nation should learn the lesson of prohibition and the crime that ensued when alcohol was illegal. "Look at tobacco, the most addictive drug, and we've reduced [use] by a third."³
- Baltimore Mayor Kurt Schmoke commented on former Surgeon General Joycelyn Elders' call for a study to legalize drugs. "I think what the Surgeon General said was absolutely courageous and correct."⁴
- Aryeh Neier, president of billionaire philanthropist George Soros's Open Society Institute, states, "The current [drug] policy is wasteful and it promotes crime and disease.... From every standpoint, it is a failure."⁵

Many other officials disagree.

Lee P. Brown, the director of the Office of National Drug Control Policy at the White House, labels legalization "a formula for self-destruction"⁶ and warns that decriminalization of drugs would mean genocide for the black community.⁷

Wayne Roques, a much-published Drug Enforcement Agency spokesman, says, "Drug policies which legalize drugs would decimate the inner cities and gravely wound the suburban populations.... Legalization is a morally and intellectually bankrupt concept."⁸

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Most Americans want to know the truth about drugs and expect public policy to be based on facts and not myths. Yet myths about legalization abound. Consider:

MYTH #1: ILLICIT DRUGS ARE NO WORSE THAN LEGAL DRUGS LIKE ALCOHOL AND TOBACCO.

Marianne Apostolides of the pro-legalization Lindesmith Center wrote in the *Wall Street Journal*, "Marijuana is safer than other substances such as nicotine and steroids. Most people who use marijuana have no problem with it."⁹

Yale law professor Steven B. Duke, who wrote *America's Longest War: Rethinking Our Tragic Crusade Against Drugs*, believes, "Our biggest, worst drug problem is the tobacco problem. Legalizing drugs will reduce the use of alcohol, which is far more damaging than any popular illegal drug."¹⁰

The fact that some dangerous substances are legal does not mean that all dangerous substances should also be legal -- especially when there are significant differences between the substances in question. Clearly, alcohol and tobacco can be quite harmful. They have a major impact on morbidity and mortality in the United States.

- Alcohol is a cause or contributing factor in most traffic deaths and nearly half of all murders, sexual assaults, robberies and other violent crimes. More than 40,000 babies are born at risk each year because their mothers drank alcohol during pregnancy.¹¹
- Similarly, tobacco kills over 400,000 people each year in the United States, and the British medical journal, *Lancet*, estimates that tobacco is the cause of death for 20 percent of the people in the developed world.¹²
- Nevertheless, a given dose of cocaine or crack is far more dangerous than a drink of alcohol. Alcohol has an addiction rate of 10 percent, whereas cocaine has an addiction rate as high as 75 percent.¹³

And when cocaine is combined with marijuana, it can be deadly. According to a study in *Pharmacology, Biochemistry and Behavior*, an increase in heart rate due to cocaine was markedly enhanced if preceded by smoking marijuana.¹⁴ The dual use creates greater risk of overdose and more severe cardiovascular effects from the cocaine. An article in *Schizophrenia Research* found that up to 60 percent of schizophrenic patients used non-prescription psychoactive drugs.¹⁵

By itself, marijuana is a dangerous drug as well. A joint of marijuana is far more carcinogenic than a cigarette. Microbiologist Tom Klein of the University of South Florida reports, "We've tried working with [marijuana smoke], and it's so toxic, you just get it near the immune system and it [the immune system] dies." Klein found that THC [tetrahydrocannabinol -- the active ingredient in marijuana] suppresses some immune system responses and enhances others.¹⁶

A study in the *Journal of Allergy and Clinical Immunology* found that marijuana smoke is often contaminated by the fungus, *aspergillus*.¹⁷ Another study in the *Journal of the American Medical Association* found that cases of allergic sinus infection with the same fungus came from recreational use of contaminated marijuana.¹⁸

A study in *Drug and Alcohol Dependence* found that cannabis [marijuana] users react very slowly in performing motor tasks and suffer disability in personal, social and vocational areas. They also indicate a higher score for neurotic and psychotic behavior.¹⁹

A study in *American Review of Respiratory Diseases* found that marijuana smoke is as irritating as tobacco smoke; when used together, marijuana and tobacco cause the small oxygen-exchanging parts of the lung to shed cells that first become inflamed.²⁰

A 1995 study in *The New England Journal of Medicine* suggests that illicit drugs such as marijuana and cocaine can interfere with male sperm production.²¹

A study in *Cancer* found that the children of women who smoke marijuana are 11 times more likely to contract leukemia.²² Mothers who smoke marijuana also contribute to low birth weight and developmental problems for their children and increase the risk of abnormalities similar to those caused by fetal alcohol syndrome by as much as 500 percent.²³

Kasi Sridhar, a professor at the University of Miami's Sylvester Comprehensive Cancer Research Center, reports finding large numbers of marijuana smokers among younger cancer patients. While only 17 percent of the patients in his study were marijuana smokers, two-thirds of the patients younger than 45 smoked cannabis.²⁴

Since the 1970s there have been more than 10,500 scientific studies which demonstrate the adverse consequences of marijuana use.²⁵ Many of these studies draw upon data collected when most of the marijuana available in the U.S. was far less potent than that available today. Indeed, drug czar Lee Brown says that marijuana on the streets today is up to 10 times more potent than a generation ago. This fact contributes to its addictive nature.²⁶

MYTH #2: LEGALIZATION WILL DRIVE THE CRIME RATE DOWN.

Syndicated columnist Abigail Van Buren endorses legalization. She wrote in her column, "Dear Abby," that, "The legalization of drugs would put drug dealers out of business." She added that it would also reduce the prison population and create a perpetual source of tax revenue.²⁷

Former Surgeon General Elders told a National Press Club luncheon, "Sixty percent of violent crimes are drug- or alcohol-related.... Many times they're robbing, stealing and all of these things to get money to buy drugs.... I do feel that we would markedly reduce our crime rate if drugs were legalized."²⁸

Professor Steven Duke told an America Online computer network audience, "Without a doubt, the problem of violent crime would be ameliorated [by legalizing drugs]. I think drug prohibition causes half of our serious crime."²⁹

Rep. Barney Frank (D-Ma.) supports legalization. "We make a mistake, with the serious law enforcement problems we have today, to get the police to arrest people who smoke marijuana.... We are wasting \$10 billion a year trying to physically interdict drugs."³⁰

The new president of the American Bar Association, George Bushnell, favors legalizing marijuana and cocaine. He believes legalization will cut crime.³¹

Legalizers believe most black market and organized syndicate involvement in the drug business would die and that drug-induced crime would decrease with drug legalization. But these assertions are not supported by the facts.

The United States experimented with legalization and it failed. From 1919 to 1922, government-sponsored clinics handed out free drugs to addicts in hopes of controlling their behavior. The effort failed. Society's revulsion against drugs, combined with enforcement, successfully eradicated the menace at that time.³²

California decriminalized marijuana in 1976, and, within the first six months, arrests for driving under the influence of drugs rose 46 percent for adults and 71.4 percent for juveniles.³³ Decriminalizing marijuana in Alaska and Oregon in the 1970s resulted in the doubling of use.³⁴

Patrick Murphy, a court-appointed lawyer for 31,000 abused and neglected children in Chicago, says that more than 80 percent of the cases of physical and sexual abuse of children now involve drugs. There is no evidence that legalizing drugs will reduce these crimes, and there is evidence that suggests it would worsen the problem.³⁵

Legalization would decrease drug distribution crime because most of those activities would become lawful. But would legalization necessarily reduce other drug-related crime like robbery, rape, and assault? Presumably legalization would reduce the cost of drugs and thus addicts might commit fewer crimes to pay for their habits. But less expensive drugs might also feed their habit better, and more drugs means more side effects like paranoia, irritability and violence. Suggestions that crime can somehow be eliminated by redefining it are spurious.

Free drugs or legalizing bad drugs would not make criminal addicts into productive citizens. Dr. Mitchell S. Rosenthal, expert on drugs and adolescents and president of Phoenix House, a resident treatment center in New York, said, "If you give somebody free drugs you don't turn him into a responsible employee, husband, or father."³⁶

The Justice Department reports that most inmates (77.4 percent male and 83.6 percent female) have a drug history and the majority were under the influence of drugs or alcohol at the time of

their current offense. And a surprisingly large number of convicted felons admit their crime motive was to get money for drugs. For example, 12 percent of all violent offenses and 24.4 percent of all property offenses were drug-money motivated.³⁷

Even if drugs were legalized some restrictions still would be necessary. For example, restricting the sale of legalized drugs to minors, pregnant women, police, military, pilots and prisoners would be necessary but would still provide a black market niche.

Pro-legalizers contend that government could tax drugs, thus off-setting the social costs of abuse. But history proves that efforts to tax imported drugs like opium created a black market. Earlier this century Chinese syndicates smuggled legal opium into this country to avoid tariffs. Even today, there is ample crime based on the legal drugs, alcohol, and tobacco. For example, organized crime smuggles cigarettes from states with low tobacco taxes into those with high taxes, and such activities are accompanied by violence against legal suppliers.³⁸

If now-illegal drugs were decriminalized, the government would have to determine the allowable potency for commercial drugs. But no government can okay toxic substances, so a black market would be created for higher potency drugs and those that remained banned, like the new "designer drugs."

Even pro-drug forces do not call for blanket legalization of drugs like LSD, crack, or PCP. Therefore, we would continue to have drug-related crime and illegal drug distribution organizations that would push these drugs on youngsters, who would be more easily induced into drug abuse through the availability and social sanctioning of marijuana.

Drug abuse is closely correlated with crime. The National Youth Survey found that 25 percent of youths who admitted to cocaine or heroin use also committed 40 percent of all the index crimes reported. The survey also found that youths who tested positive for cannabinoids have more than twice as many non-drug-related felony referrals to juvenile court as compared with those found to have tested negative.³⁹

The extent to which individuals commit "drug-related crimes only" is overstated. Most incarcerated "drug" offenders violated other laws as well. Princeton University professor John Dilulio found that only 2 percent -- i.e., 700 -- of those in federal prisons were convicted of pure drug possession. They generally committed other and violent crimes to earn a sentence.⁴⁰ However, 70 percent of current inmates were on illegal drugs when arrested and, if drugs become cheaper, violent crime could reasonably be expected to increase.⁴¹

MYTH #3: LEGALIZATION MAKES ECONOMIC SENSE.

Baltimore Mayor Kurt Schmoke believes drugs can be a revenue source for the government. "Remove the profit motive, and you put the dealers out of business... have government stores and buy marijuana cigarettes... nicely wrapped, purity and potency guaranteed with a tax stamp."⁴²

Ethan Nadelmann, a former Princeton University professor and now director of the Lindesmith Center, states: "Make sure that junkies have access to clean needles; make it easy for addicts to obtain methadone; give heroin-maintenance programs a chance to work; decriminalize marijuana; stop spending billions on incarcerating drug users and drug dealers. We know we can reduce drug abuse more effectively by spending that money on education, pre- and post-natal care and job-training programs."⁴³

Nadelmann told the *Rolling Stone* audience, "...The Pentagon's interdiction efforts, which cost U.S. taxpayers close to \$1 billion... had no impact on the flow of drugs.... [The] drug war has been most efficient at filling up the country's prisons and jails."⁴⁴

Dr. Robert Dupont, founding director of the National Institute on Drug Abuse (NIDA) and president of the Institute for Behavior and Health in Rockville, Maryland, refutes the economic myth. "We now have two legal drugs, alcohol and tobacco. We have 113 million current users of alcohol and 60 million tobacco users. The reason marijuana and cocaine use is so much lower is because they are illegal drugs. Cocaine and marijuana are more attractive than alcohol and tobacco. If we remove the prohibition of illegality we would have a number of users of marijuana and cocaine similar to that of tobacco and alcohol."⁴⁵

Health costs associated with legalization would be very high. And legalization would have consequences elsewhere. For example, the Drug Enforcement Administration says legalization of drugs will cost society between \$140-210 billion a year in lost productivity and job-related accidents. And insurance companies would pass on accident expenses to consumers.⁴⁶

The Institute for Health Policy at Brandeis University found that in 1990 dollars the societal cost of substance abuse is in excess of \$238 billion, of which \$67 billion is for illicit drugs. The report states, "As the number one health problem in the country, substance abuse places a major burden on the nation's health care system and contributes to the high cost of health care. In fact, substance abuse -- the problematic use of alcohol, illicit drugs and tobacco -- places an enormous burden on American society as a whole."⁴⁷

The claim that legalization provides an opportunity to tax new products is misleading. For example, total tax revenue from the sale of alcohol is \$13.1 billion a year, but alcohol extracts over \$100 billion a year in social costs such as health care and lost productivity.⁴⁸ There is no evidence to demonstrate that taxing cocaine, heroin, and marijuana would bolster revenues any more than do alcohol and tobacco, nor would the revenue from such taxation offset the social and medical costs these illicit drugs would impose.

The pro-drug lobby argues that legalization will save on enforcement costs. But elimination of drug enforcement would provide little funding for other uses. The government now spends 3.3 percent of its budget on the criminal justice system and half of that goes to enforcement. Less than 12 percent of law enforcement money goes to drug law enforcement.⁴⁹

Former Secretary of Health, Education and Welfare Joseph Califano cautions that in a post-legalization world, "Madison Avenue hucksters would make it as attractive to do a few lines [of cocaine] as to down a few beers."⁵⁰ This would line the pockets of legal drug producers, but it will clearly hurt the American taxpayer and American families.

MYTH #4: CRIMINALIZATION OF DRUGS IS LIKE ALCOHOL PROHIBITION.

Conservative columnist William F. Buckley, Jr., writes that the "...New York Bar in 1986 advocated the repeal of all federal legislation dealing with drugs, leaving it to the states to write their own policies. This will remind you of the 21st Amendment: when prohibition was repealed in 1933, each state was left free to write its own liquor laws."⁵¹

Lindesmith Institute director Nadelmann argues that "Prohibition... financed the rise of organized crime and failed miserably as social policy. Likewise, the war on drugs has created new, well-financed, and violent criminal conspiracies and failed to achieve any of its goals."⁵²

Prohibition was a solitary effort by this country while the rest of the world was essentially "wet." However, most drugs are illegal throughout much of the world. This makes enforcement much easier.

History shows that prohibition curbed alcohol abuse. Alcohol use declined by 30 to 50 percent; deaths from cirrhosis of the liver fell from 29.5 per 100,000 in 1911 to 10.7 in 1929; and admissions to state mental hospitals for alcohol psychosis fell from 10.1 per 100,000 in 1919 to 4.7 in 1928.⁵³ Mark Moore, Harvard professor of criminal justice, wrote: "The real lesson of prohibition is that society can, indeed, make a dent in the consumption of drugs through laws."⁵⁴

The DEA found that during prohibition, suicide rates decreased 50 percent. The incidence of alcohol-related arrests also declined 50 percent.⁵⁵

Yale history professor David F. Musto comments on the myth that prohibition is a good parallel for illicit drug legalization: "Unless drugs were legal for everyone, including children... illicit sale of drugs would continue. Legalization would create more drug-addicted babies, not to mention drug-impaired drivers."⁵⁶

MYTH #5: OTHER NATIONS HAVE SUCCESSFULLY LEGALIZED DRUGS.

Mr. Nadelmann points to foreign nations when he writes, "We can learn much from Europe and Australia, where governments have turned their backs on the _war on drugs._ They began by accepting the obvious: that it is both futile and dangerous to try to create a drug-free society."⁵⁷

Dr. John Marks of Liverpool, England promotes Great Britain's "enlightened" drug programs. "The results are zero drug-related deaths, zero HIV infection among injecting drug takers, a... reduction of... 96 percent [in] acquisitive crime. And perhaps most puzzling of all, a fall in the incidence of addiction, among the public at large of... 92 percent."⁵⁸

History provides evidence that legalization of drugs in foreign nations has not been successful. For example, opium was legalized in China earlier this century. That decision resulted in 90 million addicts and it took a half-century to repair the damage.⁵⁹

Egypt allowed unrestricted trade of cocaine and heroin in the 1920s. An epidemic of addiction resulted. Even in Iran and Thailand, countries where drugs are readily available, the prevalence of addiction continues to soar.⁶⁰

Modern-day Netherlands is often cited as a country which has successfully legalized drugs. Marijuana is sold over the counter and police seldom arrest cocaine and heroin users. But official tolerance has led to significant increases in addiction.

Amsterdam's officials blame the significant rise in crime on the liberal drug policy. The city's 7,000 addicts are blamed for 80 percent of all property crime and Amsterdam's rate of burglary is now twice that of Newark, New Jersey.⁶¹ Drug problems have forced the city to increase the size of the police force and the city fathers are now rethinking the drug policy.⁶²

Dr. K. F. Gunning, president of the Dutch National Committee on Drug Prevention, cites some revealing statistics about drug abuse and crime. Cannabis use among students increased 250 percent from 1984 to 1992. During the same period, shootings rose 40 percent, car thefts increased 62 percent, and hold-ups rose 69 percent.⁶³

Sweden legalized doctor prescriptions of amphetamines in 1965. During the first year of legalization, the number of intravenous "speed" addicts rose 88.5 percent. A study of men arrested during the legalization period showed a high correlation between intravenous use and a variety of crimes.⁶⁴

Dr. Nils Bejorot, director of the Swedish Carnegie Institute and professor of social medicine at the Karolinska Institute in Stockholm, believes the solution to the growing drug problem is consistent social and legal harassment of both users and dealers.⁶⁵

Great Britain experimented with controlled distribution of heroin between 1959 and 1968. According to the *British Medical Journal*, the number of heroin addicts doubled every sixteen months and the increase in addicts was accompanied by an increase in criminal activity as well.⁶⁶ And British authorities found that heroin addicts have a very good chance of dying prematurely. On the crime front, Scotland Yard had to increase its narcotics squad 100 percent to combat the crime caused by the "legal" addicts.⁶⁷

The Swiss opened a "legalized drug" area in Zurich seven years ago and local addicts were given drugs, clean needles, and emergency medical care. Unfortunately, the liberal policy backfired and the number of addicts surged to 3,500; violence surged, too. "Needle Park," as it came to be known, was a place of open warfare among rival gangs, and even police faced gunfire. Their cars

were attacked and overturned. In February 1995, officials ended the experiment, conceding that it had evolved into a grotesque spectacle.⁶⁸

In April 1994, the mayors of 21 major European cities formed a group called "European Cities Against Drugs," an acknowledgement that legalization had failed.⁶⁹

There are some countries, especially in the Middle East, which extract a high price for drug trafficking. These countries enjoy relative freedom from the plague of drug abuse and crime associated with illicit sales. This is never mentioned by legalization proponents.

MYTH #6: LEGALIZATION WOULD LEAD TO HEALTH BENEFITS.

Nadelmann states, "We should immediately decriminalize the sale and possession of small amounts of marijuana and make it easily available by prescription to those suffering from cancer, AIDS, multiple sclerosis and other diseases."⁷⁰ He tells *Rolling Stone* readers, "DEA's own administrative law judge Francis Young declared in 1988, marijuana is possibly _one of the safest therapeutically active substances known to man._"⁷¹

Arnold S. Trebach, former president of the Drug Policy Foundation, calls for the medical use of certain illegal drugs. He claims there is "no scientific or ethical reason why government denies heroin and marijuana to people suffering from cancer, glaucoma, multiple sclerosis, and other diseases."⁷²

In January 1994 the Clinton Administration decided to review the federal ban against the use of marijuana for medical purposes. Allen St. Pierre, deputy director of the National Organization for the Reform of Marijuana Laws (NORML), commented on the review decision: "It's encouraging to see that the public health service is going to get information about the efficacy of marijuana as a therapeutic agent.... If marijuana can never be made available to people suffering pain or going blind, it's never going to be legalized more generally."⁷³

Legalization advocates cite cases like that of James Burton, who has glaucoma. Drug agents seized his home for growing marijuana, and he now lives in the Netherlands where "I can buy or grow marijuana here legally, and if I don't have the marijuana, I'll go blind."⁷⁴

Burton has a rare form of low-tension glaucoma. At Burton's trial, ophthalmologist Dr. John Merritt testified that Burton needed marijuana to keep him from going blind.⁷⁵

Others claim that marijuana can be used to treat the side-effects of chemotherapy such as nausea and vomiting and the "wasting" phenomenon associated with AIDS.

There is substantial and contradictory evidence indicating that illicit drugs should not be legalized for medical purposes. Most advocates for medical use of illicit drugs only address marijuana. Consider the evidence:

- Philip Lee, Assistant Secretary of Health and Human Services, announced in July 1994, "The scientific evidence doesn't support using marijuana to treat glaucoma or nausea caused by AIDS or cancer treatment." Harvard medical school professor Lester Grinspoon has challenged Lee's decision. Grinspoon said there is only anecdotal evidence that marijuana smoking is beneficial because "the government has prevented the scientific studies for years."⁷⁶
- The DEA reports that marijuana is not accepted as medicine by a single American health association.⁷⁷
- Dr. David Ettinger, professor of oncology at the Johns Hopkins University School of Medicine, states, "There is no indication that marijuana is effective in treating nausea and vomiting resulting from radiation treatment or other causes."⁷⁸
- A research review published in the *Annals of Pharmacotherapy* found no scientific studies that confirmed the benefit of the use of crude marijuana on HIV-wasting syndrome. The use of marijuana might actually be counter-productive because it poses a needless and serious endangerment to the already compromised immune systems of AIDS patients.⁷⁹
- Two studies in a 1991 book entitled *Drugs of Abuse: Immunity and Immunodeficiency* found that the active ingredient in marijuana, THC, suppresses or interferes with the function of white blood cells, which fight bacterial infection.⁸⁰ Any reduction in the fighting power of white blood cells could accelerate an HIV-positive patient's transition to AIDS. Additionally, marijuana increases the health risk to AIDS patients because the smoke causes pulmonary problems.
- Glaucoma studies found that THC can decrease intraocular pressure. However, in order to ingest sufficient THC, the patient would have to be stoned all day. Alcohol also decreases intraocular pressure. According to Dr. Keith Green, who has served on the boards of eight eye journals, "Marijuana... has little potential future as a glaucoma medication."⁸¹

MYTH #7: LEGALIZE TO REDUCE ADDICTION RATES.

Mayor Schmoke told the 1993 Drug Policy Foundation conference, "The United States' war on drugs and similar campaigns in other countries have failed. Only a harm reduction policy, led by public health experts and emphasizing treatment, can be expected to reduce addiction."⁸²

Previous efforts to legalize drugs like marijuana saw an increase in abuse. The National Families in Action found that during the decade when 11 states decriminalized marijuana, regular use tripled among adolescents, doubled among young adults, and quadrupled among older adults.⁸³

Today, there are more than 8,000 emergency room visits for marijuana abuse each year, and 77,000 persons each year are admitted to treatment programs for marijuana abuse.⁸⁴

It is alleged that the problem may be worse today because marijuana is more addictive. The pro-legalization Lindesmith Institute challenged this in a recent *Wall Street Journal* letter. "The myth that marijuana is three times as potent [and therefore more addictive] as it was in the 1970s is based on a statistically invalid comparison. The potency of today's marijuana is measured by a large and diverse number of confiscated marijuana samples. The potency of 1970s marijuana was measured by a small and unrepresentative number of DEA-seized samples."⁸⁵

But the DEA cites tests of THC content. For example, the marijuana seized at Woodstock '69 had 1 percent THC; in 1974 the average THC was 3.6 percent; in 1984 it was 4.4 percent; and samples analyzed in 1992 were 29.86 percent. Based on these findings, DEA claims that marijuana may be between 30 and 60 times as potent as were the joints in the 1960s.⁸⁶

ONDCP director Lee Brown confirms the addictive nature of marijuana. "The public may have grown more blasé about marijuana over the years; the marijuana on the streets today is up to 10 times more potent than that available to teenagers a generation ago."⁸⁷

Cocaine is, of course, more addictive than marijuana. President William Howard Taft identified cocaine as "[M]ore appalling in its effects than any other habit-forming drug in the United States." He wanted it banned back in 1910. And the ranks of cocaine addicts grew before the substance was outlawed in 1915.⁸⁸

During the late 1960s, Dr. Marie Nyswander experimented with opiate addicts at the Rockefeller University, giving them free morphine, and saw the addicts' daily tolerance for morphine rise swiftly. Her partner, Dr. Vincent Dole, commented, "The doses on which you could keep them comfortable kept going up and up; the addicts were never really satisfied or happy. It was not an encouraging experience."⁸⁹

Nyswander noted, "Most drug abusers simply want to get high. Because the body daily develops more tolerance for abused drugs, addicts must use escalating dosages to achieve euphoria."⁹⁰

The DEA says that up to 75 percent of crack cocaine users could become addicts. And Mitchell Rosenthal believes that cheap and legal cocaine would increase addiction. He explains that "given unlimited access to cocaine, lab animals will consume increasingly greater amounts until they die.... [He points out that] in the U.S. there are between 650,000 and 2.4 million cocaine addicts."⁹¹

Dr. Mark Gold, formerly the research director at Fair Oaks Hospital in Summit, New Jersey, now a professor at the University of Florida medical school and a recognized expert on cocaine, states, "Whereas one out of ten alcohol users become alcoholics, one out of four users of cocaine become addicted. If, for example, cocaine becomes legalized and use rose from 6 million to 60 million, this would mean we would have 15 million addicts in need of treatment, without prospects for a complete cure, constantly relapsing."⁹²

Dr. Herbert Kleber of Columbia University suggests that legalizing cocaine would increase use up to sixfold. And Joseph A. Califano, founding president of the Center on Addiction and Substance Abuse at Columbia University, notes that any "stamp of legality" on cocaine would lead to big increases in the number of addicts and "light a new flame beneath health care spending."⁹³

MYTH #8: LEGALIZATION IS A CIVIL LIBERTIES ISSUE.

NORML's Allen St. Pierre states, "If you took the illegality out, pot wouldn't mean anything to rappers.... [B]ut it's an injustice they can sing about."⁹⁴

Chicago commodities trader Richard Dennis has contributed more than \$1 million to the pro-legalization Drug Policy Foundation. He opposes criminal penalties for drug use and states, "It's a self-evident proposition that people shouldn't go to jail for things they do to themselves."⁹⁵

To legalize behavior is in large measure to condone it. DEA agent Wayne Roques visits many high schools in Florida to discuss illicit drugs. At every session at least one student defends use of illicit drugs explaining, "Surgeon General Elders supports legalization. So drugs must be okay."⁹⁶

Illicit drug use is not a victimless crime because the user, his family, and society suffer social and economic costs. For example, drug use by pregnant mothers causes in utero damage to the child. It increases the risk of mortality threefold and the risk of low birthweight fourfold. Drug abuse is a key factor in most child abuse cases. In Philadelphia, cocaine is implicated in half of the cases in which parents beat their children to death, and in 80 percent of all abuse cases.⁹⁷

In the nation's capital, 90 percent of reported child abusers are also illicit drug abusers. In nearby Maryland, one-third of all car accidents involve drivers who test positive for marijuana. And a few years ago, a Conrail disaster took the lives of 16 and hurt another 175, because the train conductors were intoxicated with illegal drugs.⁹⁸ If those drugs were legal, the result would have been no less lethal to the innocent victims.

CONCLUSION

There is no "civil right" to do what is wrong or harmful to yourself, your family, or your society.

The facts show that legalization is a mistake for America because:

- Illegal drugs are more addictive and dangerous than the legal drugs alcohol and tobacco, which is verified by thousands of scientific studies.
- Legalization would result in more crime such as driving while intoxicated; child abuse, including child pornography; random violent crime; and a prosperous black market.

- Legalization has no economic justification. Taxing illicit drugs would offset only a small fraction of the social costs.
- Banning illicit drugs is not like alcohol "Prohibition." Drug laws reduce abuse and the medical costs associated with abuse. Legalization would do the opposite.
- Other nations have learned that liberalizing drug policies only leads to more addicts and unacceptable social consequences.
- Illicit drugs offer no offsetting health benefits. Rather, marijuana damages most major body systems and provides minimal help for glaucoma victims and only when they are constantly stoned.
- Cocaine is far more addictive than alcohol, and marijuana is at least 10 times more potent today than a generation ago.

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Mr. MICA. Now very patiently waiting is Mr. David Boaz, executive vice president of Cato.

Thank you for being our last panelist. You are recognized, sir.

Mr. BOAZ. Mr. Chairman, distinguished members of the subcommittee, thank you for inviting me to testify before you today on the successes and failures of our current policy and possible alternatives.

I, too, have a complete statement that I would like to submit for the record.

Mr. MICA. Without objection, so ordered.

Mr. BOAZ. Ours is a Federal republic. The Federal Government has only the powers granted to it by the Constitution. The United States has a tradition of individual liberty, vigorous civil society and limited government. Just because a problem is identified does not mean that the government ought to undertake to solve it, and just because a problem is found in more than one State does not mean that it is a proper subject for Federal policy.

Perhaps no area more clearly demonstrates the bad consequences of not following such a policy than our experience with drug prohibition. The long Federal experiment with prohibition of marijuana, cocaine, heroin and other drugs has given us unprecedented crime, corruption and incarceration, combined with a manifest failure to stop the use of drugs or to reduce their availability to children.

In the 1920's, Congress experimented with the prohibition of alcohol. In 1933, Congress recognized that prohibition had failed to stop drinking and had increased prison populations and violent crime. By the end of 1933, national prohibition was history, although in accordance with our Federal system, many States continued to outlaw or severely restrict the sale of liquor.

Today, Congress must confront a similarly failed prohibition policy. Futile attempts to enforce prohibition have been pursued even more vigorously in the 1980's and the 1990's than they were in the 1920's. The Federal Government spent \$16 billion on drug control in 1998 and has approved a budget of \$17.9 billion for 1999. State and local governments spend another \$15 billion or more every year.

These mind-boggling amounts have had some effect, as you have heard earlier today. Total drug arrests are now more than 1.5 million a year. Over 80 percent of the increase in the Federal prison population has been due to drug convictions. Drug offenders now constitute 60 percent of all Federal prisoners.

Yet, as was the case during prohibition, all the arrests and incarcerations have not stopped the use and abuse of drugs, or the drug trade, or the crime associated with black market transactions. Cocaine and heroin supplies are up. The more our Customs agents interdict, the more smugglers import. And, of course, while crime rates have fallen in the past few years, today's crime rates look good only by the standards of the recent past. They remain much higher than the levels of the 1950's.

As for discouraging young people from using drugs, a theme that has come up many times today, the massive Federal effort has been largely a dud. Despite these soaring expenditures, about half the students in the United States in 1995 tried an illegal drug before they graduated from high school. Every year for the past 20

years, at least 82 percent of high school seniors have said they found marijuana fairly easy or very easy to obtain. During that same period, according to Federal statistics of dubious reliability, teenage marijuana use fell dramatically and then rose significantly, suggesting that cultural factors have more effect than the legal war on drugs.

I would remind you that all of the terrible and heart-rending stories that we have heard today in this room have happened under a policy of prohibition, under a policy of 1.5 million arrests a year. I would suggest that is not a sign of success.

The manifest failure of drug prohibition explains why more and more people—from Baltimore mayor Kurt Schmoke to William F. Buckley, Jr., to former Secretary of State George Shultz—have argued that drug prohibition actually causes more crime and other harms than it prevents.

We care a lot about family values these days. We have heard a lot about families today. But the drug laws often break up families. Too many parents have been separated from their children because they were convicted of marijuana possession or some other non-violent offense.

Will Foster used marijuana to control the pain and swelling associated with his crippling rheumatoid arthritis. He was arrested, convicted of marijuana cultivation and sentenced to 93 years in prison, later generously reduced to 20 years in prison. Are his three children better off with a father who uses marijuana medicinally or a father in jail for 20 years?

And going to jail for drug offenses isn't just for men anymore. More than two-thirds of the 150,000 women behind bars have children.

One of them is Brenda Pearson, a heroin addict who managed to maintain a job at a securities firm in New York. She supplied heroin to another addict, and a Michigan prosecutor had her extradited, prosecuted and sentenced to 50 to 200 years. We can only hope that her elderly children will remember her when she gets out.

Drug prohibition leads to civil liberties abuses. People who compare the success of the military to the success we might have in a free society suggest that a military model is appropriate for a free society. In trying to win this unwinnable war, we have already suffered under wiretapping, entrapment, property seizures and other abuses of Americans' traditional liberties. As we deliberate the costs and benefits of drug policy, we should keep those problems in mind.

Students of American history will someday ponder the question of how today's elected officials could readily admit to the mistaken policy of alcohol prohibition in the 1920's but continue the policy of prohibition of other drugs.

Intellectual history teaches us that people have a strong incentive to maintain their faith in old paradigms even as the facts become increasingly difficult to explain within that paradigm. But when a paradigm has manifestly failed, we need to think creatively and develop a new paradigm.

The paradigm of prohibition has failed. I urge Members of Congress and all Americans to have the courage to let go of the old

paradigm, to think outside the box, and to develop a new model for dealing with the very real risks of drug and alcohol abuse. I believe that if this committee and the 106th Congress will subject the Federal drug laws to that kind of new thinking, it will recognize that the drug war is not the answer to the very real problems associated with drug use.

Thank you.

Mr. MICA. Thank you for your testimony.

[The prepared statement of Mr. Boaz follows:]

Testimony of
David Boaz
Executive Vice President
Cato Institute

before the
Subcommittee on Criminal Justice,
Drug Policy, and Human Resources
Committee on Government Reform
U.S. House of Representatives

June 16, 1999

Drug Legalization, Criminalization, and Harm Reduction

Mr. Chairman, distinguished members of the subcommittee:

Thank you for inviting me to testify before you on the successes and failures of our current policy of drug prohibition, and on possible alternatives.

Ours is a federal republic. The federal government has only the powers granted to it in the Constitution. And the United States has a tradition of individual liberty, vigorous civil society, and limited government: just because a problem is identified does not mean that the government ought to undertake to solve it, and just because a problem occurs in more than one state does not mean that it is a proper subject for federal policy.

Perhaps no area more clearly demonstrates the bad consequences of not following such rules than drug prohibition. The long federal experiment in prohibition of marijuana, cocaine, heroin, and other drugs has given us unprecedented crime and corruption combined with a manifest failure to stop the use of drugs or reduce their availability to children.

In the 1920s Congress experimented with the prohibition of

alcohol. On February 20, 1933, a new Congress acknowledged the failure of alcohol Prohibition and sent the Twenty-First Amendment to the states. Congress recognized that Prohibition had failed to stop drinking and had increased prison populations and violent crime. By the end of 1933, national Prohibition was history, though in accordance with our federal system many states continued to outlaw or severely restrict the sale of liquor.

Today Congress confronts a similarly failed prohibition policy. Futile efforts to enforce prohibition have been pursued even more vigorously in the 1980s and 1990s than they were in the 1920s. Total federal expenditures for the first 10 years of Prohibition amounted to \$88 million--about \$733 million in 1993 dollars. Drug enforcement cost about \$22 billion in the Reagan years and another \$45 billion in the four years of the Bush administration. The federal government spent \$16 billion on drug control programs in FY 1998 and has approved a budget of \$17.9 billion for FY 1999. (See Figure 1.) The Office of National Drug Control Policy reported in April 1999 that state and local governments spent an additional \$15.9 billion in FY 1991, an increase of 13 percent over 1990, and there is every reason to believe that state and local expenditures have risen throughout the 1990s.

Those mind-boggling amounts have had some effect. Total drug arrests are now more than 1.5 million a year. There are about 400,000 drug offenders in jails and prison now, and over 80 percent of the increase in the federal prison population from 1985 to 1995 was due to drug convictions. Drug offenders

constituted 59.6 percent of all federal prisoners in 1996, up from 52.6 percent in 1990. (See figure 2.) (Those in federal prison for violent offenses fell from 18 percent to 12.4 percent of the total, while property offenders fell from 14 percent to 8.4 percent.)

Yet as was the case during Prohibition, all the arrests and incarcerations haven't stopped the use and abuse of drugs, or the drug trade, or the crime associated with black-market transactions. Cocaine and heroin supplies are up; the more our Customs agents interdict, the more smugglers import. In a letter to the Wall Street Journal published on November 12, 1996, Janet Crist of the White House Office of National Drug Policy claimed some success:

Other important results [of the Pentagon's anti-drug efforts] include the arrest of virtually the entire Cali drug cartel leadership, the disruption of the Andean air bridge, and the hemispheric drug interdiction effort that has captured about a third of the cocaine produced in South America each year.

"However," she continued, "there has been no direct effect on either the price or the availability of cocaine on our streets." That is hardly a sign of a successful policy. And of course, while crime rates have fallen in the past few years, today's crime rates look good only by the standards of the recent past; they remain much higher than the levels of the 1950s.

As for discouraging young people from using drugs, the massive federal effort has largely been a dud. Despite the soaring expenditures on antidrug efforts, about half the students in the United States in 1995 tried an illegal drug before they

Figure 1

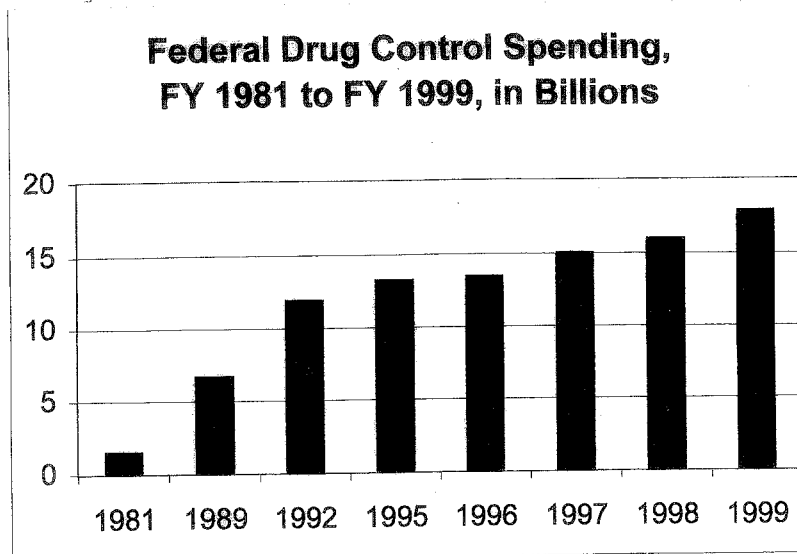
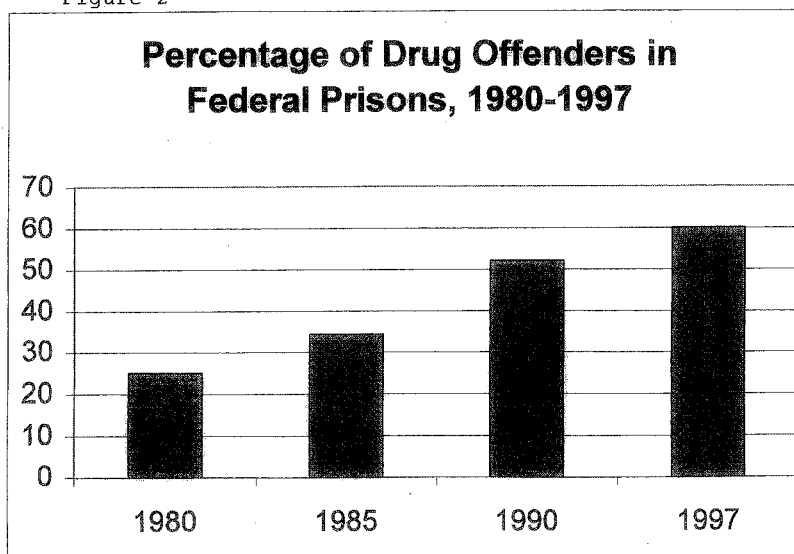


Figure 2



graduated from high school. According to the 1997 National Household Survey on Drug Abuse, 54.1 percent of high school seniors reported some use of an illegal drug at least once during their lifetime, although it should be noted that only 6.4 percent reported use in the month before the survey was conducted. Every year from 1975 to 1995, at least 82 percent of high school seniors have said they find marijuana "fairly easy" or "very easy" to obtain. During that same period, according to federal statistics of dubious reliability, teenage marijuana use fell dramatically and then rose significantly, suggesting that cultural factors have more effect than "the war on drugs."

The manifest failure of drug prohibition explains why more and more people--from Baltimore mayor Kurt Schmoke to Nobel laureate Milton Friedman, conservative columnist William F. Buckley Jr., and former secretary of state George Shultz--have argued that drug prohibition actually causes more crime and other harms than it prevents.

The Failures of Prohibition

Congress should recognize the failure of prohibition and end the federal government's war on drugs. First and foremost, the federal drug laws are constitutionally dubious. As previously noted, the federal government can only exercise the powers that have been delegated to it. The Tenth Amendment reserves all other powers to the states or to the people. However misguided the alcohol prohibitionists turned out to be, they deserve credit for honoring our constitutional system by seeking a

constitutional amendment that would explicitly authorize a national policy on the sale of alcohol. Congress never asked the American people for additional constitutional powers to declare a war on drug consumers.

Second, drug prohibition creates high levels of crime. Addicts are forced to commit crimes to pay for a habit that would be easily affordable if it were legal. Police sources have estimated that as much as half the property crime in some major cities is committed by drug users. More dramatically, because drugs are illegal, participants in the drug trade cannot go to court to settle disputes, whether between buyer and seller or between rival sellers. When black-market contracts are breached, the result is often some form of violent sanction, which usually leads to retaliation and then open warfare in the streets.

Our capital city, Washington, D.C., has become known as the "murder capital" even though it is the most heavily policed city in the United States. Make no mistake about it, the annual carnage that stands behind America's still outrageously high murder rates has nothing to do with the mind-altering effects of a marijuana cigarette or a crack pipe. It is instead one of the grim and bitter consequences of an ideological crusade whose proponents will not yet admit defeat.

Third, drug prohibition channels over \$40 billion a year into the criminal underworld. Alcohol prohibition drove reputable companies into other industries or out of business altogether, which paved the way for mobsters to make millions through the black market. If drugs were legal, organized crime

would stand to lose billions of dollars, and drugs would be sold by legitimate businesses in an open marketplace.

Fourth, drug prohibition is a classic example of throwing money at a problem. The federal government spends some \$16 billion to enforce the drug laws every year--all to no avail. For years drug war bureaucrats have been tailoring their budget requests to the latest news reports. When drug use goes up, taxpayers are told the government needs more money so that it can redouble its efforts against a rising drug scourge. When drug use goes down, taxpayers are told that it would be a big mistake to curtail spending just when progress is being made. Good news or bad, spending levels must be maintained or increased.

Fifth, the drug laws are responsible for widespread social upheaval. "Law and order" advocates too often fail to recognize that some laws can actually cause societal disorder. A simple example will illustrate that phenomenon. Right now our college campuses are relatively calm and peaceful, but imagine what would happen if Congress were to institute military conscription in order to wage a war in Kosovo, Korea, or the Middle East. Campuses across the country would likely erupt in protest--even though Congress obviously did not desire that result. The drug laws happen to have different "disordering" effects. Perhaps the most obvious has been turning our cities into battlefields and upending the normal social order.

Drug prohibition has created a criminal subculture in our inner cities. The immense profits involved in a black-market business make drug dealing the most lucrative endeavor for many

people, especially those who care least about getting on the wrong side of the law.

Drug dealers become the most visibly successful people in inner-city communities, the ones with money, and clothes, and cars. Social order is turned upside down when the most successful people in a community are criminals. The drug war makes peace and prosperity virtually impossible in inner cities.

Sixth, the drug laws break up families. Too many parents have been separated from their children because they were convicted of marijuana possession, small-scale sale of drugs, or some other non-violent offense. Will Foster used marijuana to control the pain and swelling associated with his crippling rheumatoid arthritis. He was arrested, convicted of marijuana cultivation, and sentenced to 93 years in prison, later reduced to 20 years. Are his three children better off with a father who uses marijuana medicinally, or a father in jail for 20 years?

And going to jail for drug offenses isn't just for men any more. In 1996, 188,880 women were arrested for violating drug laws. Most of them did not go to jail, of course, but more than two-thirds of the 146,000 women behind bars have children. One of them is Brenda Pearson, a heroin addict who managed to maintain a job at a securities firm in New York. She supplied heroin to an addict friend, and a Michigan prosecutor had her extradited, prosecuted, and sentenced to 50 to 200 years. We can only hope that her two children will remember her when she gets out.

Seventh, drug prohibition leads to civil liberties abuses.

The demand to win this unwinnable war has led to wiretapping, entrapment, property seizures, and other abuses of Americans' traditional liberties. The saddest cases result in the deaths of innocent people: people like Donald Scott, whose home was raided at dawn on the pretext of cultivating marijuana, and who was shot and killed when he rushed into the living room carrying a gun; or people like the Rev. Accelyne Williams, a 75-year-old minister who died of a heart attack when police burst into his Boston apartment looking for drugs--the wrong apartment, as it turned out; or people like Esequiel Hernandez, who was out tending his family's goats near the Rio Grande just six days after his 18th birthday when he was shot by a Marine patrol looking for drug smugglers. As we deliberate the costs and benefits of drug policy, we should keep those people in mind.

Students of American history will someday ponder the question of how today's elected officials could readily admit to the mistaken policy of alcohol prohibition in the 1920s but continue the policy of drug prohibition. Indeed, the only historical lesson that recent presidents and Congresses seem to have drawn from the period of alcohol prohibition is that government should not try to outlaw the sale of alcohol. One of the broader lessons that they should have learned is this: prohibition laws should be judged according to their real-world effects, not their promised benefits.

Intellectual history teaches us that people have a strong incentive to maintain their faith in old paradigms even as the facts become increasingly difficult to explain within that

paradigm. But when a paradigm has manifestly failed, we need to think creatively and develop a new paradigm. The paradigm of prohibition has failed. I urge members of Congress and all Americans to have the courage to let go of the old paradigm, to think outside the box, and to develop a new model for dealing with the very real risks of drug and alcohol abuse. If the 106th Congress will subject the federal drug laws to that kind of new thinking, it will recognize that the drug war is not the answer to problems associated with drug use.

Respect State Initiatives

In addition to the general critique above, I would like to touch on a few more specific issues. A particularly tragic consequence of the stepped-up war on drugs is the refusal to allow sick people to use marijuana as medicine. Prohibitionists insist that marijuana is not good medicine, or at least that there are legal alternatives to marijuana that are equally good. Those who believe that individuals should make their own decisions, not have their decisions made for them by Washington bureaucracies, would simply say that that's a decision for patients and their doctors to make. But in fact there is good medical evidence about the therapeutic value of marijuana--despite the difficulty of doing adequate research on an illegal drug. A recent National Institutes of Health panel concluded that smoking marijuana may help treat a number of conditions, including nausea and pain. It can be particularly effective in improving the appetite of AIDS and cancer patients. The drug

could also assist people who fail to respond to traditional remedies.

More than 70 percent of U.S. cancer specialists in one survey said they would prescribe marijuana if it was legal; nearly half said they had urged their patients to break the law to acquire the drug. The British Medical Association reports that nearly 70 percent of its members believe marijuana should be available for therapeutic use. Even President George Bush's Office of Drug Control Policy criticized the Department of Health and Human Services for closing its special medical marijuana program.

Whatever the actual value of medical marijuana, the relevant fact for federal policymakers is that in 1996 the voters of California and Arizona authorized physicians licensed in the state to recommend the use of medical marijuana to seriously ill and terminally ill patients residing in the state without being subject to civil and criminal penalties.

In response to those referenda, however, the Clinton administration announced, without any intervening authorization from Congress, that any physician recommending or prescribing medicinal marijuana under state law would be prosecuted. In the February 11, 1997, Federal Register the Office of National Drug Control Policy announced that federal policy would be as follows: (1) physicians who recommend and prescribe medicinal marijuana to patients in conformity with state law and patients who use such marijuana will be prosecuted; (2) physicians who recommend and prescribe medicinal marijuana to patients in conformity with

state law will be excluded from Medicare and Medicaid; and (3) physicians who recommend and prescribe medicinal marijuana to patients in conformity with state law will have their scheduled-drug DEA registrations revoked.

The announced federal policy also encourages state and local enforcement officials to arrest and prosecute physicians suspected of prescribing or recommending medicinal marijuana and to arrest and prosecute patients who use such marijuana. And adding insult to injury, the policy also encourages the IRS to issue a revenue ruling disallowing any medical deduction for medical marijuana lawfully obtained under state law.

Clearly, this is a blatant effort by the federal government to impose a national policy on the people in the states in question, people who have already elected a contrary policy. Federal officials do not agree with the policy the people have elected; they mean to override it, local rule notwithstanding--just as the Clinton administration has tried to do in other cases, such as the California initiatives dealing with racial preferences and state benefits for immigrants.

Congress and the administration should respect the decisions of the voters in Arizona and California; and in Alaska, Nevada, Oregon, and Washington, where voters passed medical marijuana initiatives in 1998; and in other states where such initiatives may be proposed, debated, and passed. One of the benefits of a federal republic is that different policies may be tried in different states. One of the benefits of our Constitution is that it limits the power of the federal government to impose one

policy on the several states.

Repeal Mandatory Minimums

The common law in England and America has always relied on judges and juries to decide cases and set punishments. Under our modern system, of course, many crimes are defined by the legislature, and appropriate penalties are defined by statute. However, mandatory minimum sentences and rigid sentencing guidelines shift too much power to legislators and regulators who are not involved in particular cases. They turn judges into clerks and prevent judges from weighing all the facts and circumstances in setting appropriate sentences. In addition, mandatory minimums for nonviolent first-time drug offenders result in sentences grotesquely disproportionate to the gravity of the offense. Absurdly, Congress has mandated minimums for drug offenses but not for murder and other violent crimes, so that a judge has more discretion in sentencing a murder than a first-time drug offender.

Rather than extend mandatory minimum sentences to further crimes, Congress should repeal mandatory minimums and let judges perform their traditional function of weighing the facts and setting appropriate sentences.

Conclusion

Drug abuse is a problem, for those involved in it and for their family and friends. But it is better dealt with as a moral and medical than as a criminal problem--"a problem for the

surgeon general, not the attorney general," as Mayor Schmoke puts it.

The United States is a federal republic, and Congress should deal with drug prohibition the way it dealt with alcohol Prohibition. The Twenty-First Amendment did not actually legalize the sale of alcohol; it simply repealed the federal prohibition and returned to the several states the authority to set alcohol policy. States took the opportunity to design diverse liquor policies that were in tune with the preferences of their citizens. After 1933, three states and hundreds of counties continued to practice prohibition. Other states chose various forms of alcohol legalization.

Congress should withdraw from the war on drugs and let the states set their own policies with regard to currently illegal drugs. The states would be well advised to treat marijuana, cocaine, and heroin the way most states now treat alcohol: It should be legal for licensed stores to sell such drugs to adults. Drug sales to children, like alcohol sales to children, should remain illegal. Driving under the influence of drugs should be illegal.

With such a policy, Congress would acknowledge that our current drug policies have failed. It would restore authority to the states, as the Founders envisioned. It would save taxpayers' money. And it would give the states the power to experiment with drug policies and perhaps devise more successful rules.

Repeal of prohibition would take the astronomical profits out of the drug business and destroy the drug kingpins that

terrorize parts of our cities. It would reduce crime even more dramatically than did the repeal of alcohol prohibition. Not only would there be less crime; reform would also free police to concentrate on robbery, burglary, and violent crime.

The War on Drugs has lasted longer than Prohibition, longer than the War in Vietnam. But there is no light at the end of this tunnel. Prohibition has failed, again, and should be repealed, again.

Mr. MICA. I would like to recognize first for the purpose of questions Mr. Barr, the gentleman from Georgia.

Mr. BARR. Thank you, Mr. Chairman.

Mr. Glasser, I just have a couple of quick questions for you.

I would like to say that I really appreciate the work of the ACLU in a lot of different areas—privacy rights, asset forfeiture—and I know, Mr. Ehlers, you mentioned that earlier. I appreciate your reference to that. It isn't that we disagree on every issue. There are a lot of issues that we do agree on and that we work for, and I appreciate very much the work that the ACLU does in those and many other areas as well.

We do have, I think, a fundamental policy difference on drugs. There were a couple of terms that you used—I note you were very careful about defining certain terms, but a couple of terms you used, Mr. Glasser, I wanted to ask your definition of. What is drug abuse as opposed to drug use?

Mr. GLASSER. Think of the difference between an alcoholic who is always in a stupor and gets up in the morning and drinks a quart of vodka every day and those of us who go home at night and share a bottle of wine at dinner or have a scotch or two, even if we do it every night, and go in to work and lead productive and stable lives. That is the difference between use and abuse.

Mr. BARR. So it would be the difference between—

Mr. GLASSER. Compulsive dysfunctional use, a heavy use of a substance as opposed to occasional, moderate, responsible use.

Mr. BARR. In terms of alcohol usage, we draw such a distinction, for example, in not making it necessarily illegal in every instance to convict somebody for driving after they have had a drink of alcohol. However, we try, and I think we have succeeded in large part over the years, in developing a somewhat sound scientific basis for measuring whether or not somebody's faculties and facilities to react and act to stimuli around them, for example, in driving a car, where to react improperly poses a danger to them and more importantly to other people, and we draw a distinction. We say it is not illegal unless it can be shown reasonably. We do draw some lines.

Mr. GLASSER. And it is not illegal if they are not in a car. It is not illegal if they are home.

Mr. BARR. I am just using the example of driving a car, where you inherently would pose a danger to other people.

Is it your view, then, that mind-altering drugs can be used in certain amounts without significantly impairing a person's ability to act and react to the world around them in a safe manner?

Mr. GLASSER. First of all, I would apply exactly the same standard to marijuana or any other drug that we apply to alcohol in terms of driving a car. If you are impaired for any reason while you are driving a car, you should not be driving a car and you should be subject to sanctions for doing it.

But that is a different question than whether or not you are impaired at home with two friends while you are sitting around and having a little party on a Saturday night. There you can get drunk, can't you? And as long as you don't go out and drive a car and put someone else in danger, the government has no authority to intervene in your life with its police power and put you in jail.

That is the same standard that I am talking about. When we come across the person who cannot control the use of alcohol and whose life is in a shambles, we still do not consider it a criminal problem. We don't exactly always know how to solve it, and the tale of Darryl Strawberry and millions of other people whose names are not as well known teaches us that this is not an easy problem to solve, but we know that, with respect to alcohol, we don't do it with prison, and we don't do it with cops. That is what I am saying.

Mr. BARR. Thank you.

One other term that you used was a productive user. I am not quite sure what you mean.

Mr. GLASSER. I mean a person who is productive. I mean that—

Mr. BARR. Who is productive yet also uses drugs? Not that using drugs makes you productive.

Mr. GLASSER. I mean the CEO of a major company who is on the cover of Fortune magazine and the only reason he may not be admitting that he smokes marijuana the way you and I drink red wine is because it is stupid to admit to a crime.

Mr. BARR. You are not outing somebody, are you? You are not outing a CEO?

Mr. GLASSER. That is why I haven't used any names.

But that is what I mean by productive. I mean, when you have 70 million people who have admitted to using marijuana, you almost can conclude inevitably that most of those people are people you would like your kids to grow up to be like and that they are using marijuana in no way different than you use wine.

Mr. BARR. We probably disagree on that as well.

Mr. GLASSER. But then we have to find out why we disagree.

Mr. BARR. But you are, I am sure, being a very learned and very, very well read gentleman, you are aware of the studies that have been done over the years, not just recently but going back many years, about the cost to the productivity of individuals, corporations and companies, large and small, with regard to drug usage?

Mr. GLASSER. Actually, Mr. Barr, I think those studies are less conclusive with respect to the conclusion you draw than you think. The ACLU is about to put out a study on the utility of urine testing in employment settings and the relationship of drug use off the job to productivity, to absences. You would be surprised.

Mr. BARR. I will agree with you to the extent that some of the figures that I see from some of these studies, they are sort of like this Y2K issue, we had some witnesses come in on that and they said it would cost a trillion dollars.

To some extent, I don't want to argue over the exact magnitude of it, but in talking even anecdotally with employers of small businesses, for example, they are very forthcoming in indicating the dropoff in productivity, the danger posed to other people when people try and use machinery and so forth. So there are costs.

Mr. GLASSER. How do they know this?

Mr. BARR. I suspect that any good employer can tell if an employee is dozing off on the job because of drug usage. Sometimes you can smell it. Sometimes it is because of drug tests.

Mr. GLASSER. What about if they use marijuana on a Saturday night and then it was Wednesday? What then?

Mr. BARR. I suppose if one could establish that you can absolutely discretely say, OK, drug usage on day 1 will have no effect whatsoever on day 2, 3, 4, 50, 100 or 125, your position might have some merit.

Mr. GLASSER. And so isn't that worth finding out?

Mr. BARR. I think to a large extent we probably have found out an awful lot. Maybe not so conclusively that every scientist and every doctor is willing to say with definitiveness, yes, this is exactly how it is. We have some studies up here that some scientists and doctors agree on. Others say there is certainly room for more study.

But, from a practical standpoint, I think a lot of employers would take exception to saying that people that use marijuana and then come into the job are productive individuals. There are some costs.

Mr. McDonough, with regard to the comparison as many draw, or the distinction, as many draw between alcohol usage up to the point where it does not demonstrably, measurably, significantly interfere with a person's ability to react and act to stimuli around them, do you think that alcohol usage is the same as the usage of mind-altering drugs? In other words, those on the Federal Schedule of Controlled Substances?

Mr. McDONOUGH. Well, I think not. I would like to just take a few minutes to say why I think that.

I have heard some figures bandied about rather freely. I would like to just recap them. The fact that 70 some million people in America used to use drugs is true. I think it is good that drugs are illegal because over 60 million of them have stopped using drugs, which I think is a very good outcome. The casual use of drugs as a benign event, nonthreatening, I will tell you, sir, with 120,000 dead in the decade of the 1990's alone, I don't think so. I actually do think there is a debilitation with a significant portion of drug users that leads, in fact, to death and a lot of room before death, not just to the people that suffer from it but their families as well, as well as our neighborhoods.

In this regard, of the casual, do it in your home, it is not a problem, I would ask that we take a look at the children who end up in foster homes. The statistics that I have reviewed several times show me that some 60 to 70 percent of the children in the United States in foster homes are there because within the nuclear family you had the instance of substance abuse. So the idea that it is a harmless, benign pastime, I just can't agree with.

That gets us into the analogy of Prohibition, which has been mentioned at this table three times. I have heard it often. It would have you think that Al Capone was the product of Prohibition. With that came Tommy guns and with that came murder rates.

I will tell you that in the United States I have looked at the statistics and would like to submit them for the record. Between 1900 and 1915 the murder rate in the United States per 100,000 went up 800 percent. It is true that during the period of Prohibition, there was a marginal increase in the murder rate, another 12 percent above that 800 percent. But I would tell you today that the murder rate is below what it was both before Prohibition and after

Prohibition. So to draw the analogy that Prohibition causes Tommy guns and Al Capone and murder and we see that repeated with drugs just doesn't seem to wash.

In regard to prisons, I would just like to make this statement. I do believe we can do an awful lot in this country with drug courts and coerced abstinence, meaning treatment for those in the criminal justice system, but I have to say it is an absolute myth that we have filled our prisons with the casual smoker of a harmless bong. I did take a look at Florida's prison statistics before I came here. I would like to submit that for the record. I would tell you of the 65,000 plus in prison in late 1997, there were 14 people there, that is 14, not 1,400, there for the primary offense of the possession of marijuana. In every one of those cases, it was at a degree, at a level that made you believe that they, in fact, were trafficking in marijuana.

So I will tell you that without any hesitation, statistically I can report that there is no one in the Florida prison with only one conviction of a marijuana possession offense. Of the 14, all of them had prior records; and some had other serious crimes along with that.

So when Mr. Maginnis talks about this series of myths, I think he is exactly right. Not that we can't do better with our laws in getting treatment, prevention and cutting supply, I think we should do that, but to surrender, that it is hopeless, that it is an abomination to abuse the rights of the individual to continue as we are, I think is a far overblown case. Drugs are serious, drugs do alter the mind. Dr. Leshner demonstrated that.

Mr. BARR. Is that why they call them mind-altering drugs?

Mr. McDONOUGH. That is why they call it that. It is a mess. I think making them legal actually makes the mess worse.

One final thing, I listened to the story about talking to children about the use of drugs. When I was at the national level, we would survey again and again the 80 percent of our children that don't use drugs.

By the way, that dispels a myth right there. Eighty percent of our children between the ages of 12 and 17 don't use drugs. At the worst of it, a senior in high school, about 25 percent are current drug users. But to come to the point when you ask the 80 percent why don't you use drugs, the overwhelming answer is, "My mother and my father told me not to." It is as simple as that.

Mr. BARR. Do you find a corresponding statistic on the other side that there is a disturbing correlation between brothers, sisters, parents that use drugs and that is given as a reason those teenagers in the 20 percent give for their use of drugs?

Mr. McDONOUGH. That is exactly right. I have done that as well. I have gone to them and that 20 percent. I put it this way: "Have your parents ever talked to you about using drugs?" The overwhelming answer is no. The other thing I ask, which is a very touchy one, "is there drug use in your family?" A significant portion say yes. What they see is what they do.

Mr. BARR. That comports with my experience as a U.S. Attorney in dealing with this issue and communities in the northern district of Georgia.

Mr. Ehlers, I would like to discuss very briefly the concept of harm reduction which seems sort of a domestic version I suppose of our Kosovo policy to some extent. Because if you say that, well, we are going to let people use drugs so that we reduce the harm, there is—and I know that no matter how strong and how well-researched a medical study or a scientific study there is, some people just won't believe it, but there are, in fact, very, very sound scientific studies, some of which we have already introduced into the record today, that indicate that just marijuana, to say nothing of the other much more serious drugs, marijuana usage does have direct, serious negative effects on the human immune system, the autoimmune system. It can hasten the onset of AIDS in HIV patients.

We also know from studies that marijuana severely damages various human organs over time. We have seen with regard to some substances the effect on the brain. Another study was referred to earlier with regard to the detrimental effect of prolonged marijuana usage on the human reproductive system, particularly in males. We know certainly about the effects, well-documented, on the heart and the lungs of marijuana usage.

Dozens of studies show also that there is a psychiatric component to both drug usage as well as withdrawal from drug usage. Withdrawal from marijuana, for example, can create—does create a propensity toward violent or aggressive behavior.

If, in fact, one says that, well, we look at drugs as harm reduction; we let people use drugs because to not do drugs would somehow create more harm; in light of these studies, particularly those that show that marijuana does damage to the immune systems of HIV and AIDS patients at a rate at least twice as fast as those who do not use marijuana, how can you really advocate the use of marijuana for HIV and AIDS patients and say that this is harm reduction if in fact it demonstrably and by scientific evidence hastens the onset of AIDS and hastens death in these patients?

Mr. EHLERS. I haven't seen that research that you are talking about. All I do know is I have met HIV and AIDS patients who get relief from using medical marijuana. They are all over the place, whether it be in California or here in DC. The HIV/AIDS community has been some of the biggest advocates on behalf of medical marijuana. It helps their wasting syndrome.

If you are taking lots of pills in order to try to combat your illness, then you need something to help keep those pills down. You need something to help you eat. And so time and again, we have seen AIDS patients who have used medical marijuana to stimulate appetite and to end their nausea and that helps them live.

Mr. BARR. But if you, in fact, read these studies and were, in fact, convinced that there is some merit to it that shows that, aside from those other results of marijuana usage, we will leave that aside for the moment, if it could be shown, as I believe it has been, that the use of marijuana does have very serious detrimental, long-term—insofar as you can speak of long term in somebody with terminal AIDS—results, would you still maintain that it is a benefit to give them marijuana even though it may hasten the onset of their death?

Mr. EHLERS. You would have to weigh the evidence against using marijuana as a means to increase weight, to end nausea. You would have to weigh that evidence against any potential increase in the spread of the HIV virus.

Like I said, I haven't seen that evidence. The HIV patients who use medical marijuana right now say it really benefits them, so I have to take their word for it.

Mr. BARR. With regard to the increased propensity for violence by marijuana users and other drug users, both during the use of the drugs and, as has been shown in studies, in withdrawal, would this also be something that, if you saw these studies and they seemed to be scientifically based, would cause you to rethink in any way your advocacy of marijuana in terms of so-called harm reduction?

Mr. EHLERS. If I saw that evidence. But I noted when you said that, I have some quotes from the Institute of Medicine report. What they have to say is, "a distinctive marijuana THC withdrawal syndrome has been identified, but it is mild and subtle compared to the profound physical syndrome of alcohol or heroin withdrawal. Compared to most other drugs, dependence among marijuana users is relatively rare."

So the Institute of Medicine didn't find it. I don't know where that evidence would come from.

Mr. BARR. In that case, drawing the analogy, should alcoholics be given free alcohol? Would that be considered harm reduction?

Mr. EHLERS. No. Because alcoholics, they can't function properly on the use of alcohol.

Mr. BARR. Heavy marijuana users can?

Mr. EHLERS. That is not what I am advocating.

Mr. BARR. So you are not advocating marijuana usage?

Mr. EHLERS. No.

Mr. BARR. Are you opposed to marijuana usage?

Mr. EHLERS. No.

Mr. BARR. Is there some middle ground there that I am missing?

Mr. EHLERS. Yes, there is. I don't think marijuana smokers should be imprisoned. That is what it comes down to. I don't think they should use, but I don't think they should be imprisoned, either.

Mr. BARR. So your basis is really not so much a harm reduction or medical but more, as Mr. Glasser's is, more of a legal—or Mr. Boaz's is basically a legal one. These are not the sort of things the government should be regulating?

Mr. EHLERS. Ultimately, I don't think the government should be involved in arresting nonviolent marijuana users if they are adults.

Mr. BARR. With regard to, I noticed in your testimony on page 3—

Mr. EHLERS. The full testimony?

Mr. BARR. Yes, your paper here. On page 3, you say, other maintenance therapies should be explored, including the use of—I can't pronounce that, but it does go on, I can pronounce heroin maintenance—based on the successful programs in England and Switzerland.

How do you define successful programs in England and Switzerland? How do you gauge? How do you determine their success?

Because, like Dr. Maginnis, I have been over there. Granted, my perspective in going over there was probably different from yours, but I have seen, at least to some extent, the methadone clinics over there. I have gone to the shooting galleries they have in Switzerland. I have seen mothers go into these, leave their babies out on the streets for hours on end, with nobody watching them because it is more important for them to go in and shoot up at a shooting gallery at government expense than it is to pay attention to what is happening with their children.

I don't measure that—I don't say, hey, that's a successful program. We ought to emulate it. How do you measure the success of the programs in England and Switzerland on heroin maintenance?

Mr. EHLERS. I measure success by the reduction of crime in Switzerland. They found a 60 percent reduction in crime among people who were in the program.

There is also an increase——

Mr. BARR. Heroin use would be a form of crime prevention?

Mr. EHLERS. It wasn't about crime as far as the crime of possessing heroin. It was the crime of going out to steal in order to support a habit. So, yes, it is used as a crime prevention program, as is methadone maintenance in a way. It also increased employment, decreased homelessness, stabilized people's lives, brought people into treatment. A lot of people weren't interested in heroin maintenance after they tried it. They wanted to go into treatment.

Mr. BARR. That is not my experience when I was over there just a couple of years ago talking with some of the doctors at the government-run clinics. They said, for example, that they would find that once people got into the program and were able to come by several times a day and get their drugs from the government, they would lose their interest in maintaining a job; they would lose their interest in their family; and the most important thing every day was getting by the clinic at a certain time so they could get shot up.

Here again, I am not quite sure whether that is a success or whether you would measure success simply because that person is no longer committing crimes. He or she doesn't have to. They can just come to the clinic and get their drugs.

It seems almost a circular argument that, hey, this is a successful program because we're giving them what they want so they don't have to go out and take it from somebody else, but I am not quite sure that it has an effect, as you say, on unemployment, other than perhaps increasing it because they feel they don't have to or can't maintain a job because they are constantly going over to the clinic.

Mr. EHLERS. I just can tell you what I saw in the research. The research showed that there was an increase in employment, a decrease in unemployment. There is a stabilization of lives.

I can give you the research if you would like. I have it.

Mr. BOAZ. Congressman, could I add one sentence in response to that?

As a nonheroin user, I would consider a program successful if it reduced the amount of crime that I and my family had to be subjected to as we walk through a city like Washington, DC, or Zurich. It would be better if people cured their heroin addiction, but it is

certainly a success for the rest of society if crime went down 60 percent.

Mr. BARR. With regard to one other question that I posed earlier, Mr. Ehlers, to an earlier panelist with regard to studies documented in the Marijuana and Medicine book that we have introduced into the record here that show demonstrably a very negative effect on human reproductivity. If you see this study and you conclude, as I think is pretty obvious, that it does have an effect on the abnormal development and production of spermatozoa in humans, would that be something that would be a success if we say it is OK for people to smoke marijuana and use other drugs, notwithstanding the possible effect or very likely effect it would have on birth defects and so forth? Would this also be harm reduction?

Mr. EHLERS. I don't think it is OK to smoke marijuana. That is not really the point.

One, I think there is a lot of conflicting evidence on the health effects of marijuana. I think Ira mentioned earlier another book that we would like to introduce into the record, "Marijuana Myths, Marijuana Facts." That looks at all the scientific research, and overall it shows that the negative health effects of marijuana are fairly benign. I don't think the research is there.

Mr. BARR. I would respectfully say you are somewhat selective in research.

On page 4 of your paper, you have as a footnote No. 8 to the following statement: "The Institute of Medicine found marijuana to be an effective medicine." But if you look, as you have properly done, at the quote in your footnote No. 8, it simply says that the accumulated data indicates a potential therapeutic value for cannabinoid drugs. I don't think that is quite the same thing as saying it is an effective medicine. Would you agree with that? That you might have overstated the case a little bit?

Mr. EHLERS. I should have used a better quote like from the principal investigator, Dr. John Bentsen, who said, "we concluded there are some limited circumstances in which we recommend smoking marijuana for medical uses."

Mr. BARR. With regard to the Drug Policy Foundation, is the money that you all receive from George Soros received directly from him or does it come through other conduits?

Mr. EHLERS. We receive a grant from the Open Society Institute to run our grant program.

Mr. BARR. So it doesn't come directly from Mr. Soros? It comes from the Open Society Foundation of his?

Mr. EHLERS. That is a foundation that he established, yes.

Mr. BARR. How much do you receive? Is there a set amount that you receive each year or does it vary?

Mr. EHLERS. This year the grant program received \$1.75 million.

Mr. BARR. Is that consistent with prior years or has it gone up or down?

Mr. EHLERS. Yes, I think that is fair. I am not exactly sure, but I think that is about the same as what has happened in the past.

Mr. BARR. Before I turn back to the chairman, Mr. Maginnis, as you have indicated, I know you have done extensive research and travel to Switzerland and the Netherlands and some of the other countries where they have gone further down the road toward le-

galization than we have at this point. Would you care to take just a couple of minutes—and I appreciate the chairman's indulgence—but just take a couple of minutes in response, to reflect on some of the other material we have gone over here in the last several minutes on the concept of harm reduction and whether or not the programs whereby citizens of Switzerland, for example, are allowed on a regular basis, several times each day, to go shoot up with drugs, whether this is indeed a benefit and a harm reduction.

Mr. MAGINNIS. Yes, sir, I have visited Switzerland six times in the last 3 years specifically to look at the drug issue. It is interesting with regard to what the Swiss Government has been doing that even the Dutch Government, who is known for its drug policy, has been very critical of the outcome of the Swiss experiment.

The World Health Organization just a couple of months ago really condemned the outcome. They said, this is not science. They didn't use the word quackery, but if in fact you read their study, they come to that conclusion.

And the INCB, the International Narcotics Control Board, just in May released a finding that this study or this experiment by Switzerland is misleading; it doesn't accomplish what it set out to do. And it set out to supposedly show that you could reduce harm, that you could help return people to effective lifestyles, healthy lifestyles and so forth by giving them heroin. Of course, that changed radically as they went through. They added people and so forth.

Now, with regard to crime, I interviewed the doctor who ran one of the clinics in Zurich, and they had an official from Bern, and he put together this so-called crime part. They used data that they picked up from the Bern Police Department on 40 of their addicts. Then, unfortunately they extrapolated those facts across the entire experiment, and they have really—it has been distorted in the press, the real facts, about the crime reduction.

When you begin to ask addicts—and I did, I put together a video with the assistance of the Swiss that oppose this. And it is interesting, when we interviewed addicts coming out after having received their heroin shots, many just openly acknowledge, yeah, we take cocaine on the side. Where do you get the money for that? They didn't really want to tell us. We came to the conclusion after watching and discussing this with them, quite frankly, they were probably engaging in illegal activity to get their additional money.

A lot of what you hear about crime is more anecdotal than factual. Employment, the government gives them jobs—meaningless jobs for the most part. They are not putting together BMWs and Mercedes over there, not these heroin addicts. For the most part, they are sitting around waiting for their next heroin shot, as you indicated, Congressman.

There are very few people, very few in this 3-year experiment that ever went on to meaningful treatment. In fact, they are closing treatment facilities in Switzerland because they can't get enough of these heroin addicts. Because they are getting free dope from the government, they are not going to the treatment. So they are closing them down.

And as far as the overall effect, as I showed you in that slide, there is a great tolerance in that country. It is a great country, but the fact is that their drug policy—and they have already gone

through two constitutional referendums. They are probably going to have another one before long, those constitutional referendums. First, the people were confused, quite frankly, the government was supporting their heroin maintenance program. And the second one, of course, they came out and said, no, we are not going to legalize drugs.

They are not really sure where they are going, but I can tell you from talking to many teachers and public officials that the effect is having a significant impact on the kids. The kids are using marijuana at much higher rates than they ever have before, and it continues to go up. Their view of heroin is not what it was 20 years ago. It is much more tolerant.

I have seen the same thing in Holland. General McCaffrey went to Holland last summer. There was quite a lot of media play in that. He was very critical and rightfully so. Their figures that were posted by Interpol aren't quite squaring with what they want to accept by their country.

I can remember—and I will stop with this. At Rotterdam, I went into the basement of a church where I talked with a heroin and a cocaine dealer, and I saw his dealings there. They were allowed to operate there, and anybody can come in and buy heroin. Anybody can use it right there.

I watched this guy “chasing the dragon” which is basically sniffing this stuff, heroin, up into his nose. Then they go off, and they meander through the streets. They are not very coherent, and they are going to significantly increase certainly the public loitering problem. But they have really pulled down that beautiful part of the city into a terrible scourge on what otherwise is a pretty productive community.

Mr. BARR. Is Mr. Soros involved also in channeling money to the Vienna foundation which supports these sorts of movements?

Mr. MAGINNIS. I understand Mr. Soros has contributed to some organizations that promote liberal drug laws in Switzerland. As far as the Netherlands, I can't say specifically on that.

Mr. BARR. Are you familiar, Mr. Ehlers, whether the figure, as I understand it, of \$20 million that Mr. Soros has put into the Vienna foundation to further the legalization and expand the legalization effort is accurate or not?

Mr. EHLERS. I don't know anything about that foundation or whether they have gotten any money.

Mr. BARR. Thank you.

Mr. MICA. Thank you.

Mr. Boaz, you seemed to like the Baltimore model sort of addiction as an alternative. Is that something that you support? You said that crime went down and you cited Mayor Schmoke, I guess it is, as someone who you said we should go to a more liberal policy.

Mr. BOAZ. I did cite Mayor Schmoke, yes.

Mr. MICA. Do you think that is a good model? He has instituted that.

Mr. BOAZ. No, I am not particularly excited about the Baltimore model. I cited Mayor Schmoke as somebody who has come to realize——

Mr. MICA. Would you say it would bring crime down?

Mr. BOAZ. My policy would, yes. If we eliminated the criminal penalties for the use and sale of these drugs, it would significantly reduce crime. People would be able to buy other mind-altering drugs in the same sorts of stores where they buy alcohol today, and they would not have to commit crimes in order to get those drugs, and the dealers would not have to shoot each other when they have a dispute.

Mr. MICA. In Baltimore, they have adopted some of that policy under his leadership. Through 1996, we saw almost 40,000 people as heroin addicts. Mr. Cummings, who sits right over here, told me that the figure is closer to 60,000. That is 10 percent of the population.

Mr. BOAZ. I find that implausible, Mr. Chairman.

Mr. MICA. He told me 60,000. He cited it in hearings, that he estimates in Baltimore. This is 2 years old and an official record given to me by the DEA. That would be about 10 percent of the population. Now, if we took that great model and we applied it on the United States, we have about 260 million, we would have 26 million heroin addicts as an alternative. How is that sounding?

Mr. BOAZ. Mr. Chairman, nobody seriously believes that. If you had mandatory heroin use in the United States you couldn't get 26 million addicts.

If I could just make one suggestion——

Mr. MICA. This model seems to indicate that one city that has tried a liberalized policy has an incredible percentage of people that have become addicts. And I venture to say—I don't have the statistics here on the decrease in crime, but it certainly doesn't mirror New York, and it doesn't mirror the Nation as a whole. There has to be some cost to 39,000 people as heroin addicts. Wouldn't you say there is some cost involved?

Mr. BOAZ. There would be, if there were 39,000 heroin addicts.

Mr. Chairman, I have not——

Mr. MICA. The information given to me by the DEA——

Mr. BOAZ. I understand that. I have not studied the Baltimore situation.

I would suggest the first problem with that chart is that you show 1950 and 1996. A lot of change has happened between 1950 and 1996. A fair chart would at least show how many heroin addicts there were in Baltimore when Kurt Schmoke was elected mayor and then whether there has been a change; and then if you can show that it doubled, and you have plausible figures, we have something to discuss.

But the change from 1950 to 1996 cannot be attributed to any single policy.

Mr. MICA. You say there are not 39,000——

Mr. BOAZ. I am skeptical of that number, but I admit I have not studied Baltimore.

Mr. MICA. Again, Mr. Cummings tells me the figure is much higher. He just lives there, and that is his neighborhood, so he probably wouldn't know.

I have heard repeated comments that we have first-time marijuana users, just users of marijuana, behind bars. Mr. McDonough, you testified that there were 14 folks in the State of Florida.

Mr. McDONOUGH. That is correct. In 1997.

Mr. MICA. In 1997. Some of those had other records.

Mr. McDONOUGH. In every case they had some other records.

Mr. MICA. Mr. Glasser, are you from New York?

Mr. GLASSER. I am. But I don't know how many heroin addicts there are.

Mr. MICA. This is an interesting study of incarceration that was just published in April that really debunks the theory that first-time drug users or simple even first-time felons involved with use of illegal drug substances are incarcerated. It was completed by the State of New York—Director of Criminal Justice completed in April 1999.

I would like to submit this for the record and just read maybe one or two sentences from it. It is pretty comprehensive. Let me just read the conclusion:

this report provides an accurate and objective insight into the manner in which the New York State criminal justice system adjudicates persons charged with drug offenses. Contrary to images portrayed by the Rockefeller drug law reform advocates, drug offenders serving time in our State prison system today are committed to prison because of their repeated criminal behavior, leaving judges with few options short of prison.

This is a very detailed report, basically mirroring what they said in Florida.

Mr. GLASSER. Is that violent behavior or is that repeated criminal behavior? The repeated arrests, say, for a small amount of personal marijuana?

Mr. MICA. Again, it is documented.

Mr. GLASSER. What is documented?

Mr. MICA. These are felony convictions.

Mr. GLASSER. I understand that. But the felony convictions can be violent or they can be for possession of a small—

Mr. MICA. Possession is not, as I understand it, a felony of marijuana.

Mr. GLASSER. It can be. It depends on the amount.

Mr. MICA. Yes, and the amount.

Mr. GLASSER. All I can tell you is that the U.S. Department of Justice in 1993 produced a report, which I got from the U.S. Government Printing Office in 1994, which, on page 3 of that report, says that nearly 17 percent of the total Federal prison population were drug offenders with no prior criminal—

Mr. MICA. Could you repeat the percent again?

Mr. GLASSER. Seventeen percent of the total Federal prison population were drug offenders with no prior criminal history. Eighty-four percent of the increase in State and Federal prison admissions since 1980 were accounted for by nonviolent offenders, which generally means possession or buying or selling. And in 1995, only 13 percent of all State prisoners were violent offenders. What you are dealing with here is the major proportion of the increase that has raised our prison population up to 1.8 million is for nonviolent drug offenses. If we were getting the kingpins and the violent people, we wouldn't have any more drug market. You guys are not doing it.

Mr. MICA. This report, it just happens to deal with facts and recent facts, disputes that.

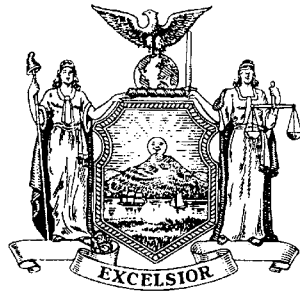
Mr. GLASSER. What about these facts?

Mr. MICA. Without objection, this report will be made part of the record, and I would be glad to insert that statement from 1993.

[The information referred to follows:]

Narrow Pathways to Prison:

The Selective Incarceration of Repeat Drug Offenders in New York State



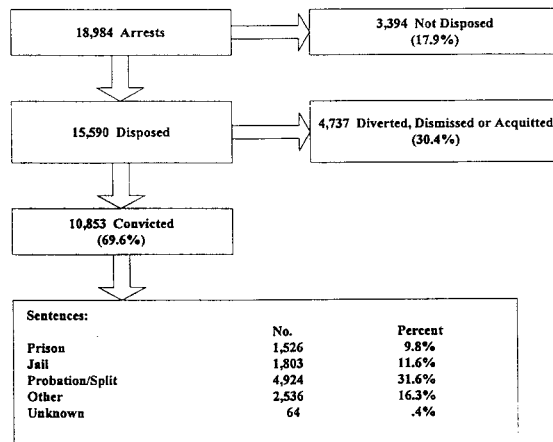
**Katherine Lapp, Director of Criminal Justice
April 1999**

Advocates seeking to reduce or eliminate the incarceration of drug offenders often focus their concerns on the following two types of offenders: (1) incarcerated drug offenders with no prior felony arrest histories; and (2) incarcerated drug offenders whose only prior felony arrests (and perhaps convictions) involve drug offenses. This report helps to illuminate the circumstances underlying the incarceration of those two groups of offenders. It reveals that the vast majority of these offenders never receive prison sentences, and most of those who are sentenced to prison have failed to abide by conditions of community supervision.

Part I: Drug Offenders with No Prior Felony Arrest (or Conviction)

Few felony drug arrestees without prior felony histories receive prison sentences in New York State. As shown below in figure 1, fewer than 10 percent of disposed felony drug arrestees without a prior felony arrest (or conviction) are sentenced to prison. The other 90 percent are diverted from the criminal justice system prior to conviction or sanctioned locally. These data suggest that the criminal justice system is very selective in its use of prison for first-time offenders.

1996 Felony Drug Arrests of Defendants with No Prior Felony Arrest (or Conviction) in New York State



Source: Division of Criminal Justice Services, Computerized Criminal History Database 3/99

In order to provide greater insight into the reasons for the State incarceration of first-time offenders arrested on felony drug charges, data on 1998 admissions into prisons in New York State were reviewed. A DOCS admission cohort was used to avoid the problem of missing dispositions in the 1996 arrest cohort and to ensure that each offender is counted only once. However, an analysis utilizing the prison commitments from the 1996 arrest cohort would produce almost identical findings.

Four factors help to explain the incarceration of drug offenders who have no prior felony histories.

Factor 1: Seriousness of the drug offense

Forty-nine percent of the 1,222 drug felons with no prior felony arrest histories who were committed to DOCS in 1998 **were arrested for class A drug offenses.**¹ Another 48 percent were arrested on class B drug charges.

Of the “first felons” *not* arrested for a class A drug offense:

Factor 2: Failure to comply with conditions of pre-trial release

Forty-eight percent had one or more bench warrants issued against them while awaiting disposition on the drug charges for which they were eventually imprisoned.

Factor 3: Rearrest while on pretrial release

Fifty-seven percent were arrested at least once while on pretrial release awaiting disposition on the drug charges. The recidivists averaged over two additional arrests while on pretrial release.

Factor 4: Misdemeanor prior arrest histories

Forty percent had one or more prior misdemeanor arrests. Those with prior misdemeanor histories averaged 2.6 arrests each.

These non-class A, first-time drug admissions will serve an average of 13 months in

¹New admissions are excluded from this analysis if they have any of the following characteristics: (1) non-drug top conviction charge, (2) prior felony arrests or convictions, (3) concurrent VFO commitment offense or (4) second felon status according to DOCS records.

prison.² The circumstances surrounding the incarceration of these felons are best illustrated through a review of typical cases. Below are summaries of the criminal histories of 20 first-time felons arrested on non-class A drug charges and admitted to prison in 1998. The 20 cases represent a computer-generated random sample of all such admissions.

Case 1:

This female is 27 at her first adult arrest in New York State and she is charged with misdemeanor drug possession. She absconds while on pretrial release and reappears almost two years later when she is arrested for felony class D drug possession. She is again released pretrial and again absconds. Two years later, she is rearrested for felony class B drug sale. The case is dismissed; she is returned to her pretrial release status and again fails to appear at a court hearing for the earlier class D drug possession arrest. Within nine months she reappears on a trespass arrest, but the case is dismissed and she is released. Two months later she is arrested for the fifth time and charged with a misdemeanor drug offense. Finally, she pleads guilty to the class D possession offense and is sentenced to 16 months to 4 years in prison.

Case 2:

The subject is a male whose first adult arrest in New York State occurs when he is 19 years of age and involves a misdemeanor drug possession offense. Within three months of that arrest, he is rearrested for felony class B drug possession, pleads to attempted possession and received a five-year term of probation. Less than two years into his probation term, he is again arrested for operating a motor vehicle while under the influence of drugs. Although he is convicted of that charge, he remains on probation. Approximately 14 months thereafter, he is rearrested for misdemeanor drug possession, his probation term is revoked and he is sentenced to two to six years in prison.

Case 3:

This male is 16 at his first adult arrest in New York State in 1994. This first arrest involves misdemeanor drug possession. Three months later he is arrested for sexual misconduct involving deviate sexual intercourse without the other party's consent and is adjudicated a youthful offender. Fifteen months later, he is involved in another incident and arrested for resisting arrest. Finally, he is arrested for five counts of felony class B drug possession and sentenced to two to six years in prison.

Case 4:

This male is 23 at his first adult arrest in New York State. He is first arrested for felony class B drug possession, convicted of attempted sale and sentenced to five years probation. Within three months of that sentence, he is rearrested on class B drug possession charges and released pretrial. While on pretrial release (and probation), he is arrested for the third time on charges of robbery, kidnaping, burglary and weapons possession. Finally, his probation is revoked and he is sentenced to 36 to 108 months in prison.

Case 5:

This male is 19 at his first adult arrest in New York State. He is first arrested on a misdemeanor marijuana sale and received an adjournment in contemplation of dismissal (ACOD). Within 10 days, he is again arrested on a misdemeanor property offense. Shortly after receiving another ACOD on the second charge, he is arrested a third

²Time served data from a 1998 DOCS release cohort indicate that first-time, non-class A drug felons serve, on average, 13 months in State prison.

time for misdemeanor marijuana possession. A third ACOD is followed by a fourth arrest (marijuana sale) eight months later. While on pretrial release, he is arrested a fifth time for misdemeanor assault and harassment. He then fails to appear for a court hearing on his fourth arrest and a warrant is issued. However, before the warrant is executed he reappears on his sixth arrest, which again involves the sale of marijuana. He pleads guilty to the assault charge and receives 60 days in jail. Seven months later he is arrested, for the seventh time, on charges of misdemeanor drug possession and receives another 60 days. Finally, three years after his initial adult arrest, he is arrested for the eighth time, charged with felony class B drug sale and sentenced to 18 to 54 months in prison.

Case 6:

This male is 39 at his first adult arrest in New York State. He is arrested nine times within a three-year period. His arrest history begins with a misdemeanor assault charge. Within three weeks, he is rearrested for petit larceny but prosecution is declined. His next arrest involved petit larceny and criminal possession of stolen property. Again, the prosecution is declined. He then reappears with a fourth arrest involving misdemeanor property offenses. While on pretrial release from the fourth arrest, he is twice rearrested for misdemeanor property offenses and released pretrial, in spite of the fact that a "failure to appear" bench warrant is issued in case four. Shortly after pleading guilty in cases five and six, he is arrested a seventh time for multiple felony class B drug sales, but is again released pretrial. Within three months and while on pretrial release, he is rearrested an eighth time for felony class B drug possession and is again released pretrial. Finally, he reappears in another three months with a third felony class B drug sale arrest, this time involving sales near drug school grounds and is sentenced to 12 to 36 months in prison.

Case 7:

This male is 24 at his first adult arrest in New York State. The first arrest involves misdemeanor charges of criminal trespass. He is released pretrial and returns within two weeks with a second arrest for misdemeanor property offenses. He then jumps bail and reappears within three months on multiple charges of felony class B drug sale and possession and is sentenced to a five-year probation term. Over the next three years, he is the subject of seven bench warrants presumably regarding misbehavior while on probation. His probation is finally revoked and he is sentenced to a term of one to three years in prison.

Case 8:

This male is 22 at his first adult arrest in New York State. He is first arrested for marijuana possession, reckless driving, and a variety of other traffic offenses. He pleads guilty to marijuana possession for which he receives a jail term. Within a year, he is rearrested for felony-level marijuana possession and the unlicensed operation of a motor vehicle. He pleads guilty and is sentenced to 16 months to 4 years in prison.

Case 9:

This male is 20 at his first adult arrest in New York State. He has a total of nine arrests within two and one-half years. His first arrest involves misdemeanor assault charges; he is released pretrial and absconds. Thereafter, he is rearrested for multiple felony class B drug sales, convicted of felony class C drug possession and sentenced to five years probation. Within 15 months of his sentence to probation, he is again arrested for misdemeanor assault and reckless endangerment involving grave risk of death. While on pretrial release from the second assault charge (and probation), he is rearrested for felony class C drug possession. Both the assault and drug charges terminate in dismissal and he remains on probation. A month later, he is again arrested for felony drug possession and released pretrial. Within four months, he is rearrested for misdemeanor assault, unlawful imprisonment, and weapons possession. He is again released pretrial and rearrested two months later for the obstruction of governmental administration and resisting arrest. Four months later he has a series of two more arrests, the second of which involved another assault offense. Finally, his probation is revoked on the earlier drug possession offense and he is sentence to prison for two to six years.

Case 10:

This male is 16 at his first adult arrest in New York State. He has a total of five arrests in a span of two and one-half years. His history begins with a misdemeanor marijuana arrest upon which he is released pretrial and absconds. Within a month, he is rearrested for two counts of felony class B drug sale, again is released pretrial and again absconds. He reappears approximately two years later on an arrest for felony class B drug sale and possession and burglary of a dwelling. He then pleads guilty to the original marijuana charge and is released pretrial on the felony drug arrests. He absconds again, only to be returned six months later on a new arrest with charges of reckless endangerment involving the grave risk of death to another, criminal mischief and the possession of weapons. The case is adjourned in contemplation of dismissal and he remains on pretrial release in spite of the fact that numerous bench warrants are issued for failure to appear on the felony drug charges. Finally, he reappears with a misdemeanor drug arrest, pleads guilty to the prior felony drug arrests and is sentenced to two to six years in prison.

Case 11:

This male is 20 at his first adult arrest in New York State. His first arrest involves the violation of the Public Health Law regarding the sale of imitation controlled substance. While on pretrial release, he is rearrested for multiple felony class B drug sales, pleads guilty and is sentenced to a five-year probation term. The probation is revoked on a technical violation and the offender is resented to prison for 1 to 3 years.

Case 12:

This male is 38 at his first adult arrest in New York State. He is first arrested on felony class B drug sale charges. Within one month, he is arrested a second time for the same offense. The court issues multiple warrants in both cases for failure to appear for various court hearings and he is eventually sentenced to a prison term of one to three years.

Case 13:

This female is 31 at her first adult arrest in New York State. She is arrested on three occasions within 13 months. The first arrest involves multiple felony class B drug sale offenses, including sales near school grounds. Within two weeks, she is arrested again for misdemeanor drug possession, pleads guilty and is sentenced to time served (approximately eight days in jail). She continues to abscond on the felony drug case until she is arrested a third time for criminal trespass and resisting arrest, after which she is sentenced to one to three years on her first arrest.

Case 14:

This male is 16 at his first adult arrest in New York State. He has a total of five arrests within two years. He is first arrested for criminal mischief involving property damage. On the day that the case is disposed through an ACOD, he is rearrested for felony class B drug possession and loitering. He is then rearrested within a month for a grand larceny that occurred prior to his first arrest and is then sentenced to a five-year probation term for the felony class B drug arrest. Two days into his probation term, he is arrested for the fourth time with charges of criminal possession of stolen property and resisting arrest. His fifth arrest involves felony class D drug possession charges as well as resisting arrest. Finally, his probation is violated on technical grounds and he is sentenced to one to three years in prison.

Case 15:

This male is 16 at his first adult arrest in New York State. He has a total of six arrests in less than two years. The first arrest involves multiple charges of felony class B drug sale. He is released pretrial and absconds. Seven months later he is rearrested for the same offense and again released pretrial. He returns in another month with

multiple felony class B drug sale charges. Again, he is released and reappears two months later with a fourth arrest involving felony class B drug possession. At this point he pleads guilty to one of the earlier cases in satisfaction of all four and receives a prison term of one to three years. Approximately a year later, he reemerges with new arrests for felony class B drug sales, including sale near school ground, but the prosecution is declined. Less than a month later, he is rearrested for felony class B criminal possession and burglary and the charges remain undisposed at the time of this review.

Case 16:

This male is 41 at his first adult arrest in New York State. He is first arrested on multiple felony class B drug sale offenses, released pretrial and absconds. He reappears seven months later when he is arrested for misdemeanor drug possession. Two months after his second pretrial release, he is rearrested on another felony class B drug sale. He pleads to charges in the first arrest and is sentenced to one to three years in prison.

Case 17:

This male is 26 at his first adult arrest in New York State. He is charged with seven counts of felony class B drug sale and six counts of felony class B drug possession. He pleads guilty and is sentenced to a minimum term of 30 months in prison.

Case 18:

This male is 22 at his first adult arrest in New York State. He is arrested for and pleads guilty to two counts of felony class B drug sale and is sentenced to 28 months to seven years in prison.

Case 19:

This male is 37 at his first adult arrest in New York State. He is first arrested on a felony marijuana charge and sentenced to probation. Subsequent to completion of the probation term, he is rearrested on three felony class B drug sales, as well as a variety of Vehicle and Traffic misdemeanors. He pleads guilty and is sentenced to one to three years in prison.

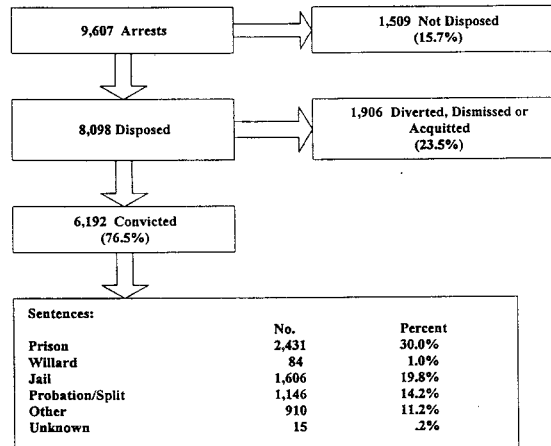
Case 20:

This male is 35 at his first adult arrest in New York State. He is arrested for multiple felony class B drug sales, including drug sales near school grounds. He pleads guilty to attempted drug sale and is sentenced to 1 to 3 years in prison.

Part II: Drug Offenders Whose Only Prior Felony History (Arrest or Conviction) Involves Drug Offenses

Most suspects who are arrested for felony-level drug crimes and whose prior felony histories are limited to drug crimes do not receive prison sentences in New York State. As shown below in figure 2, approximately 70 percent of the disposed felony arrests are either diverted from the criminal justice system prior to conviction, or sanctioned locally. Again, these data indicate a very selective use of prison even when the arrestee has a prior drug felony arrest history.

**1996 Felony Drug Arrests of Defendants with Prior Felony Arrest Histories
in New York State Limited to Felony Drug Arrests**



Source: Division of Criminal Justice Services, Computerized Criminal History Database 3/99

Many factors beyond the “second felony offender” law explain why certain felony drug arrestees with only prior felony drug histories are committed to State prison. As before, data on new admissions to DOCS in 1998 are used to identify factors contributing to their incarceration. The analysis shifts from an arrest cohort to a DOCS admission cohort to avoid the problem of undisposed cases and to insure that each offender is counted only once. Approximately 1,700 drug offenders admitted to DOCS had felony histories limited to drug offenses.³ Thirteen percent of the admissions were arrested on class A drug charges. **The following factors help to explain the incarceration of the remaining 87 percent of “drug only” admissions:**

Factor 1: Seriousness of the drug offense

Almost all (97%) of the remaining admissions were arrested for felony class B drug offenses.

³New admissions are excluded from this analysis if they have any of the following characteristics: (1) non-drug top conviction charge, (2) prior non-drug felony arrest or conviction or (3) concurrent VFO commitment offense.

Factor 2: Prior commitment to probation or prison

Seventy-two percent served prior probation or prison terms and still continued their involvement in drug crimes.

Factor 3: Prior arrest histories

These “drug only” offenders averaged **2.5 prior felony drug arrests** and **2.2 prior misdemeanor arrests**.

Factor 4: Failure to comply with conditions of pre-trial release

Twenty-eight percent had one or more bench warrants issued against them while awaiting disposition on the drug charges for which they were eventually imprisoned.

Factor 5: Rearrest while on pretrial release

Thirty-two percent were arrested at least once on pretrial release while awaiting disposition on the drug charges for which they were eventually imprisoned.

Again, a **computer-generated random sample** of 20 of the non-class A, “drug only” admissions was selected for review. The following are summaries of those histories.

Case 1:

The subject is a female whose first adult arrest in New York State occurred when she was 20 years of age. She is initially arrested for a felony class B drug sale and receives a five-year probation term. Six months into her probation sentence, she is rearrested for misdemeanor drug possession, but remains on probation with the charges dismissed. Five months thereafter, she is again arrested for a felony class B drug offense, the charges, again, are dismissed and she remains on probation. Approximately 18 months later, she is again arrested for felony class B drug sale and her probation sentence is finally revoked and she apparently is sentenced to a term in prison. She reappears five years later with an arrest for misdemeanor trespass. Within five days, she is again arrested for misdemeanor drug and property offenses, but jumps bail. She appears again four months later after an arrest on misdemeanor drug charges and trespass. Although she is sentenced to 15 days in jail, she is not held on her earlier “failure to appear” warrant. But, within six months of her release from jail, she is again arrested for a felony class B drug offense, pleads guilty on both the undisposed misdemeanor and the felony offense and receives a prison term of 27 to 54 months.

Case 2:

The subject is a male whose first adult arrest in New York State occurs when he is 20 years of age. He is initially arrested for felony class C drug possession, released pretrial and absconds. While absconded, he is arrested twice more. First he is arrested for felony class C drug possession, again released pretrial and again absconds. Then, he is arrested for felony class B drug sale and finally receives a jail sentence of one year. Within 18 months of his release from jail, he is again arrested for felony class B drug sale. However, this time he also possesses firearms. Still, he is released pretrial and absconds, only to be returned on a new felony class B drug sale offense. He resists arrest, eventually pleads guilty and is sentenced to a minimum of three years in prison.

Case 3:

The subject is a male whose first adult arrest in New York State occurs when he is 20 years of age, at which time he is arrested for felony class B drug possession and petit larceny. The charges are dismissed and he does not reappear as an arrest in New York State for a number of years. Eventually, he reappears with a new felony class B drug sale arrest and receives a probation term of three years. A few years after completing his probation term, he is again rearrested for 14 counts of felony class B drug sales, at which time he receives a prison term of 18 months to 3 years.

Case 4:

The subject is a female whose first adult arrest in New York State occurs when she is 20 years of age. Her initial arrest involves misdemeanor property offenses that are eventually dismissed. She reappears many years later on felony class B drug sale charges that are later dismissed. Within two years, she is again arrested for felony class D drug possession and serves a short jail term. Within four years, she is again arrested for felony class B drug sales, including drug sale near school grounds. She absconds while on pretrial release, but is returned. She pleads guilty and receives a minimum prison term of 18 months.

Case 5:

The subject is a male whose first adult arrest in New York State occurs when he is 34 years of age, at which time he is arrested for felony class B drug sale. The charges are dismissed, but only after he is again arrested for two new counts of felony class B drug sale. He absconds while on pretrial release, only to return five years later on charges of grand larceny and criminal possession of stolen property. The prosecution declines those charges and he again is released pretrial on the five-year-old drug charges. Once again, he fails to appear for a court hearing and is returned a year later after a new arrest for class A-1 drug sale and possession offenses. Those charges are eventually dismissed and he is released without standing trial for the undisposed drug offense. However, he returns within a year on charges of felony assault and resisting arrest and is finally sentenced to a minimum prison term of 18 months for the seven-year-old drug offense.

Case 6:

This male's first adult arrest in New York State occurs when he is 18 years of age, at which time he is arrested for felony class B drug sale and the charges are later dismissed. Within two months of the dismissal, he is arrested for felony class A-II drug possession and receives a three-year probation sentence. Within 13 months of his sentence to probation, he is again arrested for a felony class B drug sale. He pleads to a misdemeanor, serves a short jail term and remains on probation. Two months later, he is arrested on another felony class B drug offense, but still remains at liberty. Four months later, he is again arrested for felony class B drug sale and felony class A-II drug possession. Finally, his probation is revoked and he is sentenced to one to three years in prison. Within three years, he reappears with a misdemeanor drug possession arrest. Over the next 18 months he has a series of three arrests involving felony class B drug sale offenses as well as resisting arrest. The series of arrests result in a second prison sentence of three to six years.

Case 7:

This male is first arrested as an adult in New York State at 16 years of age. He is arrested for felony class B drug sale and sentenced to a five-year probation term. Within nine months of his sentence to probation, he is rearrested for felony class C drug possession. While on pretrial release (and probation), he is arrested twice more, first for misdemeanor drug possession and then for felony class B drug sale. These various arrests result in a second probation sentence of five years. Within three years, he is again arrested on felony class B drug charges and receives a prison term of five to ten years.

Case 8:

This male is first arrested as an adult in New York State at 23 years of age. His first arrest involves a property misdemeanor, for which he fails to appear for trial. Within a few months, he is rearrested on multiple drug sales including sale near school grounds and is sentenced to a five-year probation term. Within two years, he reappears with two new arrests, including criminal possession of a weapon. He still remains at liberty and, within a month of the weapon arrest, he is rearrested for felony class B drug possession. He pleads guilty to a misdemeanor possession offense and is sentenced to two days of community service. Within four months, he is again rearrested for felony class B drug sales, including sale of drugs near school grounds. Finally, he receives a prison term of 18 months to three years.

Case 9:

This male is first arrested as an adult in New York State at 19 years of age. He first appears with a felony class B drug arrest for which he receives a misdemeanor conviction and three years probation. Within a month of his sentence to probation, he is rearrested for misdemeanor drug possession. He remains at liberty and is arrested two months later on felony class B drug sale. He pleads guilty to attempted sale and is again sentenced to probation (five-year term). Six months later, he is again arrested for felony class B drug sale, absconds on pretrial release and is later acquitted at trial. Within another six months (and prior to his acquittal), he is rearrested for a variety of offenses including robbery, assault, grand larceny and criminal possession of stolen property. These charges get dismissed and he remains on probation. Finally, within another year, he is arrested on multiple felony class B drug sale offenses including a sale near school grounds. His probation is revoked and he is sentenced to 54 months to nine years.

Case 10:

This male is first arrested as an adult in New York State at 18 years of age, at which time he is arrested for three counts of felony class B drug possession and receives a one-year jail term. Within three months of his release from jail, he is again arrested for three counts of felony class B drug possession. He is released pretrial and absconds, only to return two years later with a new arrest for felony class B drug possession. He receives a prison term of one to three years.

Case 11:

This male is first arrested as an adult in New York State at 17 years of age, at which time he is arrested for felony class B drug sale (two counts). Within two week, he is twice rearrested for the same offense. He pleads guilty to one of the charges and is sentenced to five years of probation. Two months after receiving the probation sentence, he is again rearrested for felony class B drug sale. His probation is revoked and he is sentenced to one to three years in prison. He reappears two and one-half years later with two new arrests within two months of each other. Both involved felony class B drug sales. One occurs near school grounds and the other arrest included a charge for possession of burglary tools. He is then sentenced to prison for 30 months to five years.

Case 12:

This male is first arrested as an adult in New York State at 36 years of age. The first arrest involves multiple felony class B drug sale charges. Within two months of that arrest and while on pretrial release, he is rearrested for felony class C drug sale. He pleads guilty and receives a one-year jail term. Within a year of his release from jail, he is again arrested for two counts of felony class B drug sale and receives a sentence of three to six years in prison.

Case 13:

The subject is a male whose first adult arrest in New York State occurs when he is 26 years of age. The first arrest involves multiple charges of felony class B drug sale, including sale near school grounds. He is released pretrial for less than a month when he is arrested for two more counts of felony class B drug sale. These two cases result in a sentence of one to three years in prison. Less than a year later, he is again arrested for felony class B drug sales, including sale near school grounds. He is again sentenced to prison for a term of thirty months to five years.

Case 14:

This male is first arrested as an adult in New York State at 17 years of age. He is first arrested for two counts of felony class B drug sale and sentenced as a youthful offender to a one-year jail term and five years of probation. Within 18 months of his release from jail, he is rearrested for felony class B drug sales. He is released pretrial and jumps bail. Within a few months he is arrested on the bail jumping offense, his probation is revoked and he is sentenced on the drug charge to one to three years in prison.

Case 15:

This male is first arrested as an adult in New York State at 16 years of age. His initial arrest involves harassment and misdemeanor assault charges. Within one month and while on pretrial release, he is arrested for criminal trespass. He is again released pretrial and arrested one month later in possession of stolen property and burglary tools. He pleads guilty to trespass and receives 15 days in jail. Two months later, he is again arrested on criminal trespass and receives another 15-day sentence. One month later, he is arrested for three counts of felony class B drug sale and again released pretrial. He absconds and is returned and sentenced as a youthful offender to one year in jail and five years of probation, after which his original assault charge is dismissed. Nine months later, he is rearrested for felony class B drug sale. He is released pretrial and returns a month later with a felony class C drug possession charge. His probation is finally revoked and he is sentenced to one to three years in prison.

Case 16:

The subject is a female whose first adult arrest in New York State occurs when she is 39 years of age. Her first arrest involves a felony class B drug sale near school grounds and multiple drug possession charges. Within seven months and while on pretrial release, she is arrested three more times; each arrest involves felony class B drug sales, including a sale near school grounds. Finally, she is sentenced to prison for one to three years.

Case 17:

This male is first arrested as an adult in New York State at 19 years of age. His first arrest involves felony class B drug sales including sales near school grounds. While on pretrial release, he is twice rearrested. His first rearrest occurred less than a month after his initial arrest and involves harassment and obstruction of governmental administration. Within another month, he is again arrested for felony class B drug sales, including sale near school grounds. He receives a prison term of one to three years.

Case 18:

This male is first arrested as an adult in New York State at 24 years of age, at which time he is arrested for multiple counts of felony class B drug sale. While on pretrial release, he is rearrested on felony class B drug charges. The cases are consolidated and he is sentenced to a prison term of one to three years.

Case 19:

This male is first arrested as an adult in New York State at 17 years of age, at which time he is arrested for multiple counts of felony class B drug sale. He receives a youthful offender adjudication and a five-year probation term. Less than a month later, he is again arrested for felony class B drug sale. His probation is revoked and he is sentenced to one to three years in prison.

Case 20:

This male is first arrested as an adult in New York State at 37 years of age, at which time he is arrested for of felony class B drug sale, criminal trespass and resisting arrest. He absconds while on pretrial release and is returned within a month with a new series of arrests involving felony class B drug sale and criminal trespass, and eventually receives a sentence of three months in jail and five years on probation. He is on probation for less than two months when he is again arrested for multiple counts of felony class B drug sale and resisting arrest. His probation is revoked and he is sentenced to two to four years in prison.

Conclusion:

This report provides an accurate and objective insight into the manner in which New York State's criminal justice system adjudicates persons charged with drug offenses. Contrary to images portrayed by Rockefeller Drug Law reform advocates, the drug offenders serving time in our State prison system today are committed to prison because of their repeated criminal behavior leaving judges with few options short of prison.

In the past decade, numerous alternative to prison and prison division programs have been implemented to target non-violent drug abusing offenders in an effort to reduce unnecessary reliance on prison and reduce recidivism among this category of offenders. The programs range from merit time, to Shock Incarceration, D-TAP, and the Willard Drug Treatment program. Those programs and others have yielded promising results; however, as this report clearly demonstrates, when offenders continue to flaunt the system and fail to abide by the conditions of their release, the court must take swift action and impose appropriate sentences of imprisonment in order to protect society and break the cycle of crime.



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June 22, 1999

Hon. John L. Mica, Chair
106 Cannon House Office Building
Washington, DC 20515

Dear Chairman Mica:

During my testimony on June 16, you asked me for comments on the Governor's assessment of drug offender incarceration rates in New York.

Enclosed are two documents: 1) a response to that assessment by Human Rights Watch; and 2) a paper by the Correctional Association of New York on the Rockefeller drug laws. I respectfully request that both be included in the record.

Thank you.

Sincerely,


Ira Glasser

/ml
Enclosure

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The Path to Prison:
A Response to The Governor's Assessment of
Drug Offender Incarceration Rates
A Human Rights Watch briefing paper

Human Rights Watch commends Governor Pataki for placing reform of the state's drug sentencing laws on the legislative agenda for 1999. He has taken a step in the right direction by recognizing the need to lower the highest sentences imposed under the current laws and to increase the number of addicted defendants placed in drug treatment programs.

Much more is needed, however. The legislation the governor has proposed fails to address the core problem with New York's current laws—the over-incarceration of low-level offenders, resulting from mandatory minimums, an excessively harsh sentencing structure keyed solely to the weight of the drug involved, and the ability of prosecutors to wield far too much power over the sentencing of individual defendants.

The limitations in the governor's proposal reflect an unwillingness to acknowledge the extent to which low-level nonviolent drug offenders are incarcerated. The announcement of Pataki's proposed reforms was accompanied by publication of a report, "Narrow Pathways to Prison: The Selective Incarceration of Repeat Drug Offenders in New York State," by Katherine Lapp, the state's director of criminal justice. In this report, Ms. Lapp contends the state is "very selective" in its use of prison for drug offenders and that those who are sentenced to prison deserve to be there. Lapp's conclusions are surprising, given that her data shows that 3,226 drug offenders were incarcerated in 1998 even though they were either first offenders or had previously been convicted only of nonviolent drug offenses.

Human Rights Watch believes the discussion of drug policy reform is best served by an understanding of the relevant facts. Unfortunately, "Narrow Pathways" offers a limited amount of data, much of it presented in a misleading fashion. We therefore offer some fact-based responses to Lapp's claims and provide some additional relevant information on drug offenders crucial to an informed drug sentencing debate.

BRUSSELS HONG KONG LONDON LOS ANGELES MOSCOW NEW YORK RIO DE JANEIRO WASHINGTON

Claim: Few first-time felony drug arrestees receive prison sentences.

Reality: 1,526 men and women with no prior felony arrests or convictions were incarcerated in 1998.

One in seven (14%) of first time drug arrestees were incarcerated. Lapp contends their incarceration rate was only 9.8% through a statistical sleight-of-hand: she compared the number of those sent to prison against the number initially arrested. The relevant measure, however, is how many first offenders *convicted* of a nonviolent drug offense are sent to prison.

Claim: Many first offenders were incarcerated because they committed serious drug offenses, as shown by their arrest charges for Class A and B felonies.

Reality: Most incarcerated first offenders were convicted of low-level drug offenses. At the end of 1998, there were 6,382 men and women in prison for drug offenses sentenced as first offenders. Of these, 624 were convicted of Class A-1 felonies, 1,899 of Class A-2, 2,153 of Class B, and 1,706 of Classes C-E.

Arrest charges do not reflect the seriousness of a defendant's conduct. In drug cases police routinely make arrests on the highest possible charges. This permits the prosecutors to bargain for information and guilty pleas in exchange for lower charges and lower sentences. For example, drug offenders suspected of being involved in street-level drug sales of small drug amounts are routinely arrested on Class B charges and then are convicted of Class C or D level crimes.

Class A or B offenses are not limited to dangerous criminal conduct. Anyone who participates, however tangentially and in however minor a capacity, in the sale of two ounces of drugs or who possesses as little as four ounces, can be convicted of a Class A offense. Possession of half an ounce of drugs or the sale of any amount, however minute, constitutes a Class B offense.

Claim: Few drug arrestees whose prior criminal histories are limited to drug felonies ("drug-only" offenders) receive prison sentences.

Reality: 1,700 "drug-only" offenders went to prison for nonviolent drug crimes in 1998.

Two out of five, or 40%, of the drug-only offenders are incarcerated. Lapp states their incarceration rate is 30% because she compares the number of those sent to prison against those arrested. As noted above, however, the relevant measure is the number of *convicted* drug-only offenders sent to prison. But even Lapp's figure of 30%, or one in three, is remarkably high for a population that is nonviolent and consists primarily of low-level offenders.

Claim: The second-felony offender law is not primarily responsible for the incarceration of repeat drug offenders.

Reality: The basis for this claim is inexplicable. The second-felony offender law explicitly requires the incarceration of felony offenders with prior felony convictions. Lapp herself states that 72% of the 1996 arrestees with prior drug crimes had previously served prior probation or prison terms, i.e., had prior convictions for felonies.

Claim: The seriousness of the drug offense for which defendants were arrested helps explain the incarceration of "drug-only" repeat offenders.

Reality: Most incarcerated "drug-only" repeat offenders were convicted of the lowest level drug crimes.

According to the Department of Corrections, 15,922 people in New York prisons at the end of 1998 had been sentenced as second felony offenders. Only 1% were convicted of class A crimes.

Repeat Drug Offenders in Prison		
<u>Felony Class</u>	<u>Number</u>	<u>Percentage</u>
A-II	236	1%
B	4,312	27%
C-E	11,456	72%

The Path to Prison

Data from the Department of Corrections of the Division of Criminal Justice Services shows that the road to prison for drug offenders is a broad highway and not—as Lapp erroneously contends—a "narrow pathway."

Fact: *Thousands of low-level drug offenders are incarcerated each year.*

As of December 31, 1998, there were 22,386 men and women in New York prisons convicted of nonviolent drug offenses. One in four was convicted of simply possessing drugs.

Fifty-nine percent of the incarcerated drug offenders, 13,612 people, were convicted of sales or possession offenses in the three lowest felony classes—Class C, D or E. These felonies involve minute drug amounts.

Fact: Thousands of drug offenders who have not engaged in violent, serious or dangerous criminal conduct are sent to prison each year.

- Three out of four (77.5%) drug offenders sent to prison have never been convicted of a violent felony.
- One in three (31.8%) has no prior felony conviction for any crime.
- Half (50.9%) have no prior felony drug convictions.
- Half were people whose only prior criminal conduct—whether detected or undetected by law enforcement agencies—consisted of low-level nonviolent drug-related offenses.¹
- Only 9.7% have prior convictions for both drug and violent felonies.

The Lapp report chronicles the criminal history of forty representative cases of men and women arrested in 1996 for drug offenses. Many had multiple arrests and convictions on misdemeanor as well as felony drug charges, as well as histories of failing to comply with the terms of pretrial release and/or probation. Their stories illustrate a well known fact about the current criminal justice system: it functions as a turnstile operation through which thousands of minor drug offenders spin without receiving adequate supervision or any drug treatment. Sooner or later, many end up as second felony offenders sent to prison at great cost to themselves, their families, their communities and the state.

Human Rights Watch believes New York must confront forthrightly the wisdom, justice, and cost of incarcerating thousands of low-level nonviolent offenders.² Prison sentences that are disproportionate to the offender's conduct violate internationally recognized human rights as well as common sense. Whether they are first time drug offenders or people with multiple convictions for drug offenses, whether they are convicted of possession or sale, most of the drug offenders packing New York's prisons were guilty of conduct involving minute drug quantities or of playing minor roles in the drug trade. Thousands are substance abusers, and their criminal history is directly linked to their addiction.

We call for drug law reform that will enable courts to fashion proportionate, fair, and sensible sentences, including substance abuse treatment and other effective alternatives to incarceration. Mandatory minimums triggered arbitrarily by the quantity of drug involved regardless of the offender's role in the offense should be abolished.

¹John J. DiIulio Jr., "Against Mandatory Minimums," *National Review*, No. 9, Vol. 51, p. 48.

²Additional information and full citations can be found at the Human Rights Watch website at <http://www.hrw.org>. For an extensive analysis of the nature and impact of New York's drug laws, see the 1997 Human Rights Watch report, "Cruel and Usual: Disproportionate Sentences for New York Drug Offenders."

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Reform The Rockefeller Drug Laws

Enacted in 1973 when Nelson Rockefeller was governor, the Rockefeller Drug Laws require harsh prison terms for the possession or sale of relatively small amounts of drugs. For example, the harshest provision of this statute mandates a judge to impose a prison term of **no less than 15 years to life** for anyone convicted of selling 2-ounces or possessing 4 ounces of a narcotic substance. **The penalties apply without regard to the circumstances of the offense or the individual's character or background. Whether the person is a first-time or repeat offender, for instance, is irrelevant.**

Relevant Points

1. **At great expense to the taxpayer, these laws fill our prisons with low-level, non-violent offenders.**
 - There are over **22,300** drug offenders locked up in New York State prisons. It cost the state over **\$2 billion** to construct the prisons to house these people. And the operating expense for confining them comes to over **\$715 million** per year.
 - In 1998, **46.6%** of the people sent to state prison were drug offenders. In 1980, the figure was only **11%**.
 - Twenty-five percent of the drug offenders in New York State prisons, over **5500** people, were locked up for drug possession, as opposed to drug selling. It costs about **\$180 million** per year to keep these people in prison.
 - Of all drug offenders sent to NYS prisons in 1997, **nearly 80%** were never convicted of a violent felony and **nearly half** were never arrested for a violent felony.
 - Sixty percent of the drug offenders in NYS prisons were convicted of the three lowest felonies – Class C, D, or E – which involve only minute drug amounts. For example, **only ½ gram** of cocaine is required for conviction of Class D felony possession, and **1,242 people** are locked up for that offense.

(over)

2. These laws are marked by racial bias.

- Studies and experience have shown that the majority of people who use and sell drugs in NYS and the nation are white.
- African-Americans and Latinos comprise over 94% of the drug offenders in NYS prisons. African-Americans, 48.7%; Latinos, 45.5%; whereas whites make up only 4.9%.

3. Alternatives are available that save money and cut crime.

- A 1997 study by RAND's Drug Policy Research Center concluded that treatment is the most effective tool in the fight against drug abuse, finding that treatment reduces 15 times more serious crime than mandatory minimum sentences.
- Several studies sponsored by the National Institute on Drug Abuse have shown that drug treatment programs, on the whole, are successful in reducing the levels of drug abuse and crime among participants and in increasing their ability to hold a job.
- The cost of keeping an inmate in NYS prison for a year is about \$32,000. In comparison, the cost of most drug free outpatient care runs about \$2,700-4,500 per person per year; and the cost of residential drug treatment is \$17,000-\$21,000 per participant per year.

4. By wide margins, the public shows support for drug law reform.

- According to a recent Zogby International poll:
 - 64% of the public do not consider a legislator who votes for drug law reform "soft on drugs;" more than double those who do (31%).
 - 51% are more likely to vote for a legislator who supports a bill to reduce drug sentences; 25% are less likely.
 - 74% chose treatment over jail/prison for those convicted of drug possession, where only 19% chose jail/prison.
- According to a recent poll by Quinnipiac College:
 - 69% of the public would rather have the trial judge set the sentence given to drug offenders than have the court be bound by mandatory statutes.

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Rockefeller Drug Law Repeal

BACKGROUND

With the active support of then Governor Nelson Rockefeller, the New York Drug Laws were enacted in 1973, instituting lengthy prison sentences for a wide range of drug offenses. The law was amended in 1979 mainly to reduce the penalties for offenses involving marijuana. The punishments required by this law for the possession or sale of heroin, cocaine, and other hard drugs still rank among the most severe in the nation.

For example, the harshest provision of this statute mandates a judge to impose a prison term of **no less than 15 years to life** for anyone convicted of selling 2 ounces or possessing 4 ounces of a narcotic substance. The penalties apply without regard to the circumstances of the offense or the individual's character or background. Whether the person is a first-time or repeat offender, for instance, is irrelevant.

PROBLEMS

The Expense

As of December 31, 1998, there were over **23,000** drug offenders locked up in New York State prisons. It cost the state over **\$2 billion** to construct the prisons to house these people. And the operating expense for confining them comes to over **\$715 million** per year.

Prison Overcrowding

To accommodate the tremendous growth in the inmate population caused in part by the application of the Rockefeller Drug Laws, the State has spent extraordinary sums each year on building new prisons. From 1981 through 1996, the State added about **40,000** beds to its prison system, at an average construction cost of **\$100,000**, for a total capital expense, not counting debt service, of approximately **\$4 billion**. At the close of 1997's legislative session, policymakers approved another **3100** prison beds, all double-celled, virtually all expected to hold inmates charged

with disciplinary infractions, who will be kept together in their cells for at least 23 hours a day. It cost about **\$300 million** to build these new facilities. Moreover, in his fiscal year 1999-2000 budget, Governor Pataki has proposed allocating **\$360 million** to build two new double-celled prisons that will each confine 1,500 inmates. It will cost the state nearly **\$100 million** every year to operate these maximum-security facilities.

Despite these enormous expenditures, New York's prison expansion has not kept pace with the increase in the number of inmates. The State's corrections system is hobbled by crisis conditions. Prisons are overcrowded; there are not enough programs to productively occupy prisoners; and, idleness and tension levels are high. The system has been forced to double bunk or double cell over 12,000 inmates --an especially hazardous arrangement given the presence of tuberculosis and its potential to spread among inmates and staff. The State has also been forced to rush a large number of prisoners out the back door of the system, through work release and day reporting programs that have not been able to provide participants with adequate support and supervision.

The Skewed Effect on Law Enforcement

These statutes result too often in the arrest, prosecution, and long-term imprisonment of minor dealers or of persons only marginally involved in the drug trade. Major traffickers usually escape its sanctions. **The problem is that the Rockefeller Drug Laws place the main criteria for culpability on the weight of the drugs in a person's possession when he or she is apprehended, not on the actual role he or she plays in the narcotics transaction.** Aware of the law's emphasis, drug kingpins are rarely foolish or reckless enough to be caught carrying narcotics; whereas a teenage mother, employed as a courier by that same kingpin, is more likely to be picked up on the street and charged with a serious felony for having a small amount of drugs in her possession.

Another criticism of the law is that major dealers often take advantage of its provisions permitting lifetime probation sentences in exchange for cooperation in turning other drug offenders over to the authorities. Less culpable persons generally do not possess information that would be useful to prosecutors. These people often decline to plea bargain and insist on a trial instead. If these persons are found guilty, they frequently must be sentenced to a mandatory minimum term of 15 years to life in prison.

Our overriding point here is that this statute, as a principal weapon of, and as it is implemented in, the so-called 'War Against Drugs', results directly in the following misguided practice: law enforcement agencies focus their efforts on those minor actors in the trade who are the most easily arrested, prosecuted, and penalized, rather than on the middle-and high-level criminals who are drug dealing's true masterminds and profiteers.

The Injustices

The Rockefeller Drug Laws result in many individual cases of injustice, where people with no histories of violent or predatory behavior, who function barely on the margins of outlawed drug markets, are slammed with the harshest punishments our criminal justice system can dispense. For example, the Correctional Association's research in New York showed that 95 percent of the women charged as drug couriers in our sample had no previous criminal involvement. In New York,

murderers, arsonists and kidnappers face the same penalties as 'drug mules'. Rape, the sexual abuse of a child and armed robbery carry lesser sanctions.

Our research showed also that many drug mules, often poor and uneducated women, are coerced by threats of violence or tricked into transporting drugs and are therefore hardly culpable of the charges. However, many of them, facing 15 years to life in prison, plead guilty to a lesser offense in exchange for a much shorter term of incarceration.

Some who are mothers and primary caretakers of children say they are afraid to risk long-term separation from their families by presenting their cases at trial. In effect, and in a mockery of the justice system, the Rockefeller Drug Laws are being used to bludgeon guilty pleas from people who are facing long prison sentences and do not have the resources or savvy to defend themselves.

RACIAL MATTERS

The Drug Laws have a harsh and disproportionate impact on communities of color. Studies by the FBI and the National Institute for Drug Abuse have shown that whites make up the vast majority of people who consume drugs. There is also evidence to suggest that more than half of drug dealers are white. Yet, most of the people doing time in New York State prisons for a drug offense, over 90% in fact, are African-American or Latino. The specific ethnic breakdowns are: blacks comprise 48.7% of the drug offenders in state prison; Hispanics, 45.5%; whites, 4.9%.

If larger numbers of whites participate in buying and dealing drugs, why are so many more blacks and Latinos in prison for these crimes? The problem -- and it is a problem that is at least partially a function of having these drug laws on the books -- is that law enforcement efforts focus almost entirely on inner city communities of color. In New York City, for example, the police squads carrying out recent anti-drug initiatives have been sent solely into such areas.

Much of the white drug activity takes place behind the closed doors of corporate offices and suburban living rooms. By contrast, much of the drug trade in minority neighborhoods is carried out on the streets where it is much easier to make arrests.

In addition, there is probably more violence involved in the drug trade in our low income, inner city communities. The drug trade there is more visible, more disruptive to the stability of the community and, therefore, there is a greater call for a police response.

Finally, white middle and upper class people involved in drugs often have the resources and political influence to resist law enforcement attempts to punish them. Well-paid, high-powered attorneys are just one of the means such people can use to derail the effective prosecution of their crimes.

The head of the narcotics division of the Chicago Police Department may have very well been speaking for urban police leaders everywhere when he said: "There is as much cocaine in the Stock Exchange as there is in the black community. But those guys are harder to catch. Those deals are done in office buildings, in somebody's home, and there is not the violence associated with it that

there is in the black community. But the guy standing on the corner, he's almost got a sign on his back. These guys are just arrestable."

The rationale for the policy that produces this outcome might make sense superficially, but the practices are ultimately discriminatory and have a devastating impact -- by uprooting individuals and breaking up families -- on communities of color. Repealing the Rockefeller Drug Laws would remove a regressive tool from law enforcement's arsenal and would inevitably lead to a more balanced approach on the part of prosecutors and police in the fight against drug abuse.

PROPOSED CORRECTIONAL ASSOCIATION REFORM

The Correctional Association urges **repealing** the Rockefeller Drug Laws, so that prison terms would no longer be mandated for drug offenders convicted of the least serious crimes.

Flexibility in sentencing would allow judges to utilize less costly and more productive punishments for many of the minor drug offenders who have taken up increasing amounts of valuable prison space because of the impact of the Rockefeller Drug Laws. It is important to note that more than 5,600 people are locked up in New York on a conviction for merely possessing narcotics. It costs the state about \$180 million a year to keep these individuals **confined**.

AN EFFECTIVE ALTERNATIVE PUNISHMENT

The most suitable alternative punishment for these non-violent, drug-involved offenders is intensive supervision probation that includes such features as day reporting, community service, job training, **and mandatory participation in proven drug treatment programs.**^{*} Implemented properly, this program can closely monitor the offenders' behavior while simultaneously providing them with support services and making sure, where appropriate, that they repay the community and/or the victim for the property stolen or damage done.

^{*} A 1997 Study by RAND's Drug Policy Research Center found that treatment is the most effective option in the fight against drug abuse, reporting that treatment reduces 15 times more serious crime than mandatory minimum sentences. Several studies sponsored by the National Institute on Drug Abuse have also shown that drug treatment programs, on the whole, are successful in reducing the levels of drug abuse and crime among participants and in enhancing their ability to hold a job.

The added value of a well-run alternative punishment is that it gives selected offenders a critical opportunity to become law-abiding members of society. Under current practices, too many people are unnecessarily relegated to the grim and criminogenic world of state prison.

BENEFITS OF THE CORRECTIONAL ASSOCIATION PROPOSAL

Removing the Rockefeller Drug Laws from the books would have several positive effects:

- a) Expanding the use of effective alternative punishments for suitable offenders, thereby reducing the use of unnecessary incarceration, increasing the availability of needed drug treatment, and helping to make our criminal justice system more fair and rational;
- b) Saving the state substantial sums of money by reducing the number of persons occupying expensive prison space who do not have to be locked up for public safety reasons;
- c) Returning appropriate discretion to judges who could then individualize the sentencing decision for the non-violent, low-risk offender. In this way scarce prison resources could be better focused upon the most serious offenders; and
- d) Providing meaningful relief to the state's prison overcrowding problem, thereby helping to make the state's prisons safer for inmates and corrections officers and more manageable for prison administrators.

For more information on this issue, please contact Robert Gangi, Executive Director of the Correctional Association, at 212-254-5700

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Mr. MICA. This is a pretty comprehensive study of the New York prison population. I think we have heard the same thing from Mr. McDonough. There is a myth here.

Mr. Boaz, you look like you want to respond. But I want to ask you a question.

Mr. MICA. Do you—I think you indicated—and I want to be sure about this for the record—want to go beyond marijuana, that any type of substance, what is it, category one—Schedule 1, be decriminalized, no criminal penalty for possession?

Mr. BOAZ. Right. I wanted to say I don't think there is necessarily a conflict between the facts you read and the facts Mr. Glasser read. The report from New York says that most of the prisoners in New York have had prior criminal records. The report Mr. Glasser read said a large portion had not had a violent conviction. So the issue comes down to, should people who sell drugs be in jail?

Mr. MICA. That leads to my next question. These people dealing in quantities, are traffickers. Possession versus trafficking and sales. How far did you want to go on decriminalization? There is no penalty, as I understand your position. How about trafficking?

Mr. BOAZ. I would like to see drugs sold in licensed, regulated stores, not on street corners and not on playgrounds. You don't see very many liquor dealers offering liquor on school yards and playgrounds. You see people selling drugs there because it is a completely unregulated, unlicensed, illegal business. So I would like to see the business treated like alcohol, yes.

Mr. MICA. OK, so if people were dealing in the manufacture and production and trafficking in an illegal, nonregulated fashion, for example, producing moonshine you get arrested, and you want the same for illegal drugs?

Mr. BOAZ. I grew up in Kentucky and we had a lot of bootlegging and moonshining, and my father used to be one of those who tried to take people in, so, yes——

Mr. MICA. I am trying to develop a model. We talked about Baltimore. Now, let's see how you want to distribute and what types of stuff. You don't think we as a Congress or legislative body have any responsibility in controlling substances. And we have methamphetamine. You want that in the same category, even with the medical factual information shown in the chart?

Mr. BOAZ. I am not necessarily certain that there couldn't be some drug that was so dangerous, so mind altering but——

Mr. MICA. Heroin?

Mr. BOAZ. I would not put heroin in that category. I would rather have marijuana, cocaine and heroin produced by Philip Morris and distributed by licensed liquor stores, than to have it manufactured and distributed by the Cali cartel and distributed on street corners. Yes, that is right.

Mr. MICA. And meth is out of the category?

Mr. BOAZ. I think meth is a good example of something that we have seen throughout prohibition in the 1920's and 1990's, which is the creation of stronger drugs. When you have these huge profits available in an illegal business, as opposed to a legal business, you get an incentive to try to supply more and more powerful, smaller and smaller kinds of drugs.

I don't think you would see drugs like crack and meth if we had a legal drug market. If we had licensed, regulated stores where you could get marijuana and cocaine, you would not see these other kinds of drugs being produced.

Mr. MICA. Mr. Ehlers, I would like to hear about your model. Possession across the board?

Mr. EHLERS. Yes, I would say right now that is considered a decriminalization model. Adults wouldn't be prosecuted only for the possession of—

Mr. MICA. Marijuana, heroin, cocaine. Are you in the Boaz model?

Mr. EHLERS. What we are attempting to do is treat drug use and drug abuse as a health problem. The problem is if you criminalize it, if you tell people they are going to get arrested for being a drug user. You are going to push people away from help.

So that right now I think you have a situation where people are afraid to go in for treatment. Actually, there is no treatment available; but if it were available, they are afraid of criminal sanctions.

I think there is another—also the problem of heroin overdoses among youth where you have kids who are afraid they are going to be arrested and then not helping their friends get to the hospital because they don't want to get into trouble.

Mr. MICA. I am trying to get to the model you would like to see. We are a legislative body; we pass the laws for determining what is legal and illegal, what is criminal and not. The model is pretty clear, marijuana, yes. How about heroin and cocaine?

Mr. EHLERS. What I would like you to do now is, I have a full list in my testimony. I listed all those things that should be done now, namely, the repeal of mandatory minimums, much more treatment available, much more prevention available, the reform of civil asset forfeiture, restoration of civil liberties, all of those things can be done here and now. That is what I want.

Mr. MICA. What about cocaine and heroin, sales, legalization, regulation as described by Mr. Boaz? We operate basically on—actually, this Congress operates on the will of the people.

Mr. EHLERS. Right.

Mr. MICA. Believe it or not it does. When the people make up their mind they want such and such—

Mr. EHLERS. I think the people should be offered—frankly, we talk about a lot of different potential models, and we don't advocate on behalf of any of those various models that would come under regulation. Right now one thing that I think could be tried—both of the fellow witnesses have said it hasn't worked—I think there is evidence to support the possibility of heroin maintenance. That is something that could be tried. Medical marijuana, that is something that should be available.

Mr. MICA. Do you like the Baltimore model for heroin?

Mr. EHLERS. No. I am just not sure what the Baltimore model is.

Mr. MICA. Liberalization and—

Mr. EHLERS. The only thing that I was aware of that Kurt Schmoke was doing in Baltimore, was that he was expanding needle exchange programs which I have seen studies that indicate it

works, and he has gotten a lot of addicts into treatment, and he is expanding treatment.

I don't know what he is doing on arrest policy. I do know there has been a heroin use problem long before Kurt Schmoke came on board. So it is not something we can blame on Kurt. There is a long history here. He came into a situation.

Mr. MICA. What about continuing the regulation of criminalization of trafficking in heroin and cocaine, and methamphetamines?

Mr. EHLERS. I think we need to discuss the possibility of regulation, mainly the problems of prohibition and the black market which have been discussed before. A regulated market would do good things in the sense that we would no longer have criminals getting large amounts of money from the trade. We would no longer have destabilization of governments in other countries, undermining the rule of law, the huge prison system we have now. There is also tax revenue, to talk about and using that for prevention and treatment. That is a possibility. It is not something we are advocating right here and now.

Mr. MICA. Thank you.

I have tried to be open and fair in this process. In fact, I think we are three to one on this panel. The government also stated its position prior to this, the head of the drug policy office and two others. But we conducted this hearing, as I said in the beginning, to have an open and civil discussion. There is obviously a difference of opinion.

I intend to have additional hearings to the point of decriminalization looking at the Phoenix, AZ model, talking about medical use of marijuana. Some points have come out in this hearing that we need to look at, what is going on as far as promotion of these different positions; the new element raised here today about marketing on the Internet. The Internet didn't exist just a few years ago, and we have a whole new scope and range of activities. So that is the purpose of the hearing, to open the discussion. I don't know that we will reach any conclusions, and you can see there is a great diversity of opinion among you and, I am sure, the people in the audience and the members of this panel.

I did want to give Mr. McDonough some time to respond. He did want to respond. If you would do that at this time.

Mr. McDONOUGH. Thank you, Mr. Chairman. I just wanted to make a comment on the notion put before you that the fact that drugs are against the law deters people from getting treatment. Having spent a number of years looking at drug courts, the prison system and addicts, it is sad to say but what I find is an addict almost never volunteers for treatment. It is only when they are under great duress that you see them come forward. This is for the rich as well as the poor. Usually with the rich it is we know when the spouse has said that is enough, we can't tolerate this anymore or the business is about to fail or the profession is about to fail, they will quietly go and get treatment.

The vast majority that come for treatment come for it within the criminal justice system. That is to say, the law picks them up after they committed about 20 crimes—and that is what the law enforcement professionals tell me what happens—and if they are given the

option of going to drug court in lieu of prison, they will accept drug treatment.

Now, interesting to note, the success rates on that in bringing down addiction and recidivism rates are very, very good. To be specific, in Florida, I have studied the data. Since 1994 we have seen seven or eightfold improvement.

That is to say, you have seven or eight times as much success in bringing the recidivism rates down when you have coercion of the criminal justice system overhanging the treatment. That is not an undignified process for the offender, now the client. The client appears before the drug court judge, has to go to treatment, has to take his drug or her drug test on a monthly basis, often more often than that, and has to successfully get through the program every month for 12 months. After 12 months, they graduate. The ideal is they are free of drugs, employed, and no longer have a criminal activity habit.

That is what we are seeing in successes. I will tell you my experience—the statistics I have looked at it is not the criminal justice system that deters people from getting treatment. Actually, it seems to be an impetus to treatment. A very good one. So I would like to dispel that myth.

Mr. MICA. Thank you. To be totally fair, the only one I don't think I have asked a question of or given a chance to respond is Mr. Maginnis. Did you want to comment, sir?

Mr. MAGINNIS. Mr. Mica, I have a chart and I won't have to use it, but 70 percent of Americans oppose cocaine and heroin legalization because they believe, as the DEA indicated, it would lead to more violent crime in America. That is one of a number of reasons, but if you look at the Chinese opium use at the turn of the century, 100 million Chinese started using opium.

If you consider what Dr. Herb Kleeber quoted earlier by the DEA and saying how addictive cocaine is, can you imagine if Madison Avenue was to market cocaine and heroin as they have cigarettes in this country? We produce 600 billion cigarettes a year; we market all over the world. We would certainly produce a purer heroin and cocaine and package it with flavors, with everything else and it would be pretty widely available but the social consequences—the chart the drug czar showed you—would have 110 billion social consequences that would go up logarithmically if we did this.

So it is a deadly pathway. If we want catastrophe for this country, go forward.

Otherwise, I think we should listen to the sanguine and very common sense approach that the American people keep telling us that drugs are—this is the wrong direction. We need to turn off the spigots and hold these people pushing legalization accountable for what they are doing whether it's in California, Arizona, or up in Washington State. In fact, they are confusing our kids; they are contributing to more drug use and more of the problems that we have in this country, not helping.

Mr. MICA. Thank you. Mr. Barr, do you have any final questions?

Mr. BARR. Thank you, Mr. Chairman.

We had asked, Mr. Chairman, I believe, Mr. Soros to come here today and testify. I am sorry he didn't. Perhaps he will in the near future. But we know, Mr. Chairman, that those associated with the

Drug Policy Foundation, Arnold Trebach, its founder, is a legalizer advocate. We know Richard Dennis on the Drug Policy Foundation Board of Directors likewise is an advocate for legalization of all drugs, including heroin.

Ethan Nadelmann with the Lindesmith Center and Soros conduits, organizations to which he channels money for legalization efforts, is also an avowed legalizer. So that really is, Mr. Chairman, what we are talking about here. We are talking about the funding of an effort in this country similar to what we have seen overseas to legalize mind-altering drugs.

People can come up with all sorts of eloquent reasons why that isn't really what they are saying and they really don't want people to use drugs and see these awful things happen to them, but that is what we are talking about here. We are talking about legalizing drugs and saying it's OK for people in the United States of America to rely on mind-altering drugs to get by in their daily lives.

I don't know whether any panelists would relish the thought of going into an operating room and having the doctor they see before they are put under, probably for the last time, smoking a toke or doing a line of cocaine. Maybe they would. I don't know. I certainly wouldn't. But that is what we are talking about here.

We are talking about legalization of mind-altering drugs. They are called mind-altering drugs because they alter your mind, and one can argue about the extent to which that happens, but it's mind-altering drugs for that reason.

I am somewhat intrigued—and I know time is short—but I am still very intrigued by the Drug Policy Foundation and the work that it does, and perhaps we can get to that more later on if Mr. Soros would be with us. But just a couple of quick questions, Mr. Ehlers.

Does the Drug Policy Foundation—is it a 501(c)3 organization?

Mr. EHLERS. Yes.

Mr. BARR. Does the Foundation lobby in support of drug legalization policies?

Mr. EHLERS. No. We don't lobby on behalf of drug legalization policies. We do some lobbying, yes, as 501(c)3s are allowed to do.

Mr. BARR. It is your view that it is permitted under 501(c)3 status.

Mr. EHLERS. Yes.

Mr. BARR. What sort of lobbying do you do? Is it like today speaking with Members of Congress and the State legislature yourself?

Mr. EHLERS. No. We do grass-roots lobbying, too. We put out action alerts for members to respond to, and we write about legislation, which isn't necessarily lobbying. I mean, action alerts is the primary means of lobbying for us.

Mr. BARR. And you think that is not inconsistent with being a 501(c)3 organization?

Mr. EHLERS. No.

Mr. GLASSER. Mr. Barr, since I am the president of the Drug Policy Foundation board and more familiar than Mr. Ehlers, maybe I can answer——

Mr. BARR. Mr. Ehlers, maybe I can ask also, would that be consistent with the position of the Christian coalition, which recently came under fire for doing alerts and voter guides and so forth?

Mr. GLASSER. That is political partisan activity.

Mr. EHLERS. Yes, that is not——

Mr. GLASSER. Mr. Barr, as you well know—I know you are talking to him, but I am going to answer the question.

Mr. BARR. You are not appearing here as Mr. Ehlers' attorney. I am asking him the questions.

Mr. GLASSER. I am here as Mr. Ehlers' superior on the board, and if you want to know about what the Drug Policy Foundation does with respect to its tax exemption, I will tell you. He doesn't know.

Mr. BARR. Well, if I wish to hear from you on that, Mr. Glasser, I will ask you; and if I don't, I am sure in objective style, Mr. Mica will give you additional time.

Mr. GLASSER. If you wish to know the answers to the questions, you will ask me; and if you wish to harass Mr. Ehlers, you will ask him.

Mr. BARR. I really don't think that asking questions of somebody who comes up here representing a foundation or a legal entity about the work that that legal entity or organization is doing and the legal basis on which it is operating without getting into all the ins and outs of legalisms which I am not doing is harassing. And if I do, then every single witness that comes up here and is questioned about their work by any member of any panel on either side of the aisle is harassing witnesses, that's not——

Mr. GLASSER. If you want to know the answer, you would direct it to the person who knows the answer, wouldn't you? We all know what you are doing.

Mr. BARR. With all due deference, you're a great man; but I don't think you are the only one that can answer questions.

Mr. GLASSER. I am the only one on this panel who can answer those questions.

Mr. BARR. Well, we'll see.

Mr. MICA. We don't want to get into some kind of an exchange at this point. Mr. Barr was yielded the time. Mr. Barr, do you have further questions of the witness?

Mr. BARR. Just very briefly, Mr. Chairman, following onto, again, some of the policies regarding the Drug Policy Foundation.

Is the Drug Policy Foundation providing support to the drug legalization efforts in various States, including Florida, Maine, and Oregon?

Mr. EHLERS. No.

Mr. BARR. It is not engaging in any sort of activities in terms of gathering of signatures and whatnot for referenda or for petitions?

Mr. EHLERS. No.

Mr. BARR. Are you aware of any work by Mr. Soros currently similar to what was engaged in in the California effort with respect to signatures for petitions and referenda in other States?

Mr. EHLERS. No.

Mr. BARR. Is the Drug Policy Foundation or George Soros, to your knowledge, presently accepting any money from any foreign

entity which promotes drug usage, such as certain companies or entities from Colombia or Mexico?

Mr. EHLERS. Not that I am aware of.

Mr. BARR. Do you—does the Drug Policy Foundation receive any money from any foreign sources?

Mr. EHLERS. We have members in other countries, yes.

Mr. BARR. That donate money?

Mr. EHLERS. Yes.

Mr. BARR. Provide money?

Mr. EHLERS. They are members, yes.

Mr. BARR. Is that just from individuals?

Mr. EHLERS. As far as I know.

Mr. BARR. Does the Drug Policy Foundation assist any individuals or groups who are seeking to obtain drugs for personal use?

Mr. EHLERS. Could you repeat that?

Mr. BARR. Does the Drug Policy Foundation assist any individuals or groups seeking to obtain drugs for personal use?

Mr. EHLERS. No.

Mr. BARR. Mr. Glasser, I would be delighted to entertain any information you would care to provide to supplement what Mr. Ehlers provided in response to questions concerning the tax exempt status and lobbying efforts of the Drug Policy Foundation.

Mr. GLASSER. Sure. 501(c)3 organizations are permitted to do a certain amount of lobbying under 501(H) of the Internal Revenue Code, which permits various percentages of your total expenditures to be used for lobbying up to certain maximums.

So lobbying is permitted. That is different from activity that is electoral, which is not permitted. The Drug Policy Foundation does no such electoral activity. It does do lobbying, both grass roots and direct within the limits of 501(H), and it has elected, under 501(H), as has the American Civil Liberties Union Foundation and many other 501(c)3 organizations.

Mr. BARR. When you talk about electoral, does that include seeking to influence the result of a ballot or referendum in any way?

Mr. GLASSER. No. I just mean elections of individuals to public office. Referenda and initiatives are a form of lobbying. It's just direct instead of legislative, but it's lobbying.

Mr. BARR. Is that the sort of activity that is permitted, in your view, for the Drug Policy Foundation in some states?

Mr. GLASSER. Yes, it is permitted under 501(c)3 if you have elected under 501(H).

Mr. BARR. If, for example, the Drug Policy Foundation were asked to engage in activities in support of a particular candidate and you were advising them on that, you would advise them that that is not permissible?

Mr. GLASSER. Yes, that is correct.

Mr. BARR. If they came to you and asked if it was permissible to lobby in support of a drug referendum or a particular initiative or proposition concerning drug legalization and to, I guess, indirectly support those who favor it, that would be permissible?

Mr. GLASSER. That's permissible within very restrictive amounts, somewhat less than 20 percent of your total expenditures. So unless your total expenditures are very high, you don't get to spend very much; but you can spend within those statutory amounts, yes.

Mr. BARR. But if the organization has a generous benefactor and that person donates large amounts of money, in your view, the amount of money that the organization would have to engage in that sort of lobbying would increase. You say it is on a percentage?

Mr. GLASSER. Yes. It would, to a dollar limit. The limit in the law is that no matter how much money you have and no matter what the applicable percentages, you can't spend more than \$1 million. In any case, the amount of money that Mr. Soros provides the Drug Policy Foundation is entirely for a grant program in which we make grants to other organizations. So none of that money is used for any of those purposes.

Mr. BARR. When you use the figure \$1 million, is that per State or per issue or per—

Mr. GLASSER. No, that is per organization. If a 501(c)3 organization elects under 501(H) of the code to do a certain amount of lobbying, it is a percentage—graduated percentage of amounts; but in no situation can you spend more than \$1 million, no matter what the percentages are. So, say 20 percent or \$1 million, whichever is less.

Mr. BARR. Could you increase that if one established subsidiaries under that parent organization, for example?

Mr. GLASSER. No. Because the statute and the regulations define affiliated organizations in ways that have to do with whether you are controlling them or not. So you can't multiply those limits by having subsidiaries that you control.

Mr. BARR. OK. Thank you very much. Maybe this is the sort of thing we can get into later. I very much appreciate, Mr. Glasser, your elucidation; and I appreciate the testimony of the witnesses and appreciate the chairman for calling this very important hearing. Thank you.

Mr. MICA. I thank the gentleman. I have a unanimous consent request to include in the record an article entitled, "Should Safer Smoking Kits Be Distributed to Crack Users?"

[The information referred to follows:]

symposium

Q: Should 'safer smoking' kits be distributed to crack users?

Yes: It may seem outrageous, but our moral duty is to save lives — no matter whose.

BY ARNOLD S. TREBACH



Trebach, professor emeritus at American University, is the founder and former president of the Drug Policy Foundation and author of a forthcoming book on modern drug-policy reform.

I am writing this with a crack-cocaine kit next to my word processor. This is the first one I have ever seen. The small plastic envelope does not contain crack, but it does contain a small rubber mouthpiece and filters for the pipe, alcohol wipes, antibiotic ointment, vitamin C tablets and condoms — two of them.

The kit is accompanied by a pamphlet from the Bridgeport, Conn., Health Department which tells crack smokers: "Avoid cut lips.... Have safer sex.... Be careful with your stem or pipe.... Take care! Don't share!" The pamphlet is chock-full of explicit advice such as, "Don't get cut lips! Cuts caused by sharp or hot pipes can expose pipers and others to infectious diseases, especially when you have oral sex without a condom, dental dam, or a latex barrier."

My instinctive reaction is to be repulsed by much of this, the kit and the advice on the pamphlet; this is intimate behavior that should be discussed only behind closed doors. My traditional mores were jolted a bit more when I read the small print on the front of the pamphlet: "Funding provided by Drug Policy Foundation." I recently retired as president of the Drug Policy Foundation and I do not speak for it, but as I reflect on this grant, I am proud of the award and hope that the foundation and other funders provide more like it. Here is why.

Personal mores and instinctive repulsive reactions are to be heeded but they should not rule public-policy decisions in the arena of health. Much of standard medicine involves invasive procedures and advice from physicians and nurses that is, quite frankly, repulsive. Good medicine is at times embarrassing.

Middle- and upper-class folks get that advice in the privacy of a medical suite. The crack smokers among them would, one

assumes, get very direct advice on how to use crack in the most healthy fashion from their private doctors and nurses. Public-health measures, as embodied in the crack kit and the pamphlet, often involve connecting lower-class and marginalized citizens to some form of middle-class medical service.

Some years ago I labeled the underlying philosophy of this approach "medicalization." By that I meant that society should make the sometimes-difficult choice of

approaching behavior in the marginal arena that blends criminal and medical deviance by calling a doctor rather than a police officer. One of the earliest and best examples of this philosophy was embodied in the *Rollleston Report*, published in Britain in 1926, which stated that addicts were suffering from a disease and that sometimes it was proper medical treatment for doctors to provide them with their drugs of addiction on a long-term maintenance basis.

Recently, drug-control leaders in Europe came up with a broader adaptation of the *Rollleston* philosophy, which might be called "medicalization plus." They called it "harm reduction." Harm reduction reluctantly accepts the use of drugs in modern society, rejects the notion of seeking a drug-free society as inherently impossible, accepts drug users as potentially decent human beings with dignity, recognizes nevertheless that drugs do cause harm and then sets out to design programs that reduce the damage that drugs cause to individuals and to the public at large.

The logical progression from *Rollleston* to crack kits is as follows. First, addicts and drug users are worthy subjects of care and compassion. Second, drug maintenance on the drug of addiction is a proper procedure for some of them; it relieves their agonies and helps society by reducing the crime and chaos of the black market. Third, since many addicts inject and share needles if they are not easily available, it is within the medical model to provide clean needles to reduce the spread of blood-borne diseases such as hepatitis and, now much more compelling, AIDS. Fourth, addicts do not always understand the best ways of injecting; accordingly, they should be taught safe injecting practices lest they hurt themselves. Finally, because needle- (continued on page 26)

TREBACH: continued from page 24

availability programs do not reach crack smokers who spread disease by sharing pipes and risky sexual behavior, disease-prevention devices and instructions should be given to these smokers.

Harm reduction is sweeping the civilized world, especially the Western democracies, including Australia. Virtually every major drug-policy reform organization in those countries, including the Drug Policy Foundation, espouses harm reduction as its central focus. (There is no worldwide legalization lobby, as charged by Rachel Ehrenfeld and some other critics, although I personally wish there were. Thus, the charge that key harm-

reduction funders, especially George Soros, are secret legalizers is an extremist nightmare without a shred of factual basis.) Within the worldwide reform movement, harm reduction has become the accepted wisdom in the middle ground. The Bridgeport crack-outreach program fits squarely within that moderate, sensible middle ground. Not radical or chic or daring, except in a few new details — and except for those among us who want to treat drug deviants as Torquemada did Jews during the Spanish Inquisition: You have two choices — either convert to our way of believing or die.

Such a posture is morally obscene and perverse. Yet that, in effect, is what the opponents of harm reduction are saying: Harm reduction condones and encourages drug use; the only policy for a free society is zero tolerance of drug use, whatever the cost. In truth, zero tolerance condemns other human beings to a horrible, lingering death. That is what U.S. drug policy, driven by the zero-tolerance policy, does. It kills people. It is a form of genocide imposed on those who inhabit the margins of mainstream society.

This dreadful indictment is based mainly on the government's own figures and on prestigious reports on the deadly mix of drugs and AIDS, which is made even more lethal by the zero-tolerance policy. The consistency of results from recent scientific studies of the impact of needle exchange and availability are striking. Every major scholarly, medical or scientific body to inquire into this key component of harm reduction has reached favorable findings of its health benefits in that it tends to inhibit the spread of disease, especially AIDS and hepatitis.

Nevertheless, the U.S. government callously has ignored that advice and that of other experts and maintains its opposition to supporting operational funding for needle-exchange programs, which function, when they can, in a legal gray area supported by private and state and local funds. In 1997 two leading researchers — physician Peter Lurie of the University of Michigan and professor Ernest Drucke of Albert Einstein College of Medicine in New York — calculated conservatively that needle-exchange programs could have prevented up to 9,666 HIV infections among intravenous, or IV, drugs users, their sex partners and children between 1987 and 1995 in the United States.

The researchers also estimated that if more needle-exchange programs were implemented, an additional 11,300 HIV infections could be prevented by the year 2000. Translation: All 21,000 of these people will die in part because of U.S. policy, and that is just the tip of the iceberg.

The official federal data on AIDS, recently succinctly summarized by the Lindesmith Center in New York, show a continuing catastrophe unlike few in our entire history. Among African-Americans age 25 to 44, AIDS is the leading cause of death. It is the second-leading cause of death of all Americans

within that age group. Approximately half of all new HIV infections occur among IV drug users, their sexual partners and offspring. As of June 1997, 36 percent or 221,000 of all U.S. AIDS cases had occurred among IV drug users, their sexual partners or children. Of these unfortunate people, 128,000 have died. At least 5,000 of these victims were children. Fifty-three percent of all children born with AIDS were the offspring of IV drug users and their sexual partners.

While the scientific support for harm reduction is overwhelming, little of it deals with crack outreach but mainly with needle exchange. The crack programs are too new for the accumulation of much scientific data, but they operate on the same assumptions as needle exchange or needle availability. Indeed, as Mark Kinzly, a former addict who coordinates the street outreach program in Bridgeport, explains, "The crack-outreach project operates from a needle-exchange program. We saw that we were reaching injecting addicts but not enough crack smokers. If we wanted to save more lives, we had to come up with some approach to crack users who were not injecting."

The program operates under the energetic leadership of Jesus Gomez, director of the HIV program in the city health department. Kinzly spends a good deal of time on the streets in the department van that distributes clean needles, crack kits and more — food, advice and trust. There is something that goes on in that van," Kinzly told a reporter. "It's a trust factor. When they see you every day, they come to trust you." Kinzly and Gomez reach out to people often hidden from view, who live and die anonymously, ignored by hard-line drug policymakers. "When you connect with people who have no hope," Kinzly says, "they grab it! Those who do not change and get off drugs, at least they're healthier."

Beyond needle exchange and safe crack smoking is the holy grail of cure: achieving abstinence. That is part of the harm-reduction methodology, although it often is ignored by critics. Gomez says, "We always encourage the users we see to consider going in for treatment, and when they are ready we attempt to arrange that — although there are not enough treatment slots in the state. But even so, over the last two years we have gotten over 300 addicts into treatment. Those 300 people are in

Zero tolerance condemns human beings to a horrible, lingering death. It is a form of genocide imposed on those who inhabit the margins of mainstream society.

No: Such efforts will spread crack use and expand the reach of drug tragedy.

BY RACHEL EHRENFELD



Ehrenfeld is author of Narco-Terrorism and Evil Money: Encounters Along the Money Trail and writes frequently on the issues of drug policy and money laundering.

"Using crack is like playing Russian roulette where a substantial number of the chambers are filled rather than empty," says Herbert Kleber, professor of psychiatry at Columbia University and medical director of the National Center on Addiction and Substance Abuse.

"There is no 'safe way' to use it," he emphasizes, "because the danger of crack lies in the compelling way it takes control of behavior. Once crack has its control, the side effects — both physical and mental — then follow. In my 30 years in the field, crack is the most dangerous and addicting drug I've encountered."

This expert opinion is not shared by the Washington-based Drug Policy Foundation, or DPF, a grant-making and advocacy organization which funds the distribution of "safe-use" kits for crack smokers, and San Francisco's Tides Foundation, which is dedicated to promoting social diversity and change by way of grant-making. Both organizations support "alternative" drug policies, such as needle-exchange programs, under the guise of "harm reduction." Billionaire George Soros funds both. DPF received several million dollars from Soros during the last four years. Soros gave the Tides Foundation \$1 million for needle exchanges in August, saying at the time that the grant was "a lifesaver, not a ruse to legalize drugs."

Interviewed by the *New York Times* in August, Soros said that he is helping to fight "the evils and misguided policy of the drug war." Somewhat paradoxically, Soros has written that he favors the legal distribution of many banned drugs, but not the most dangerous, such as crack cocaine.

Mark Kinzly, the Bridgeport, Conn., Health Department's needle-exchange, safe-crack-use program coordinator and a founding member of the People of Color Harm Reduction Community Partnership, presented the "Piper (Crack) Smokers" user kit and the "Shoot Smart, Shoot Safe" pamphlet on Nov. 18 at the Soros-funded Lindesmith Center in New York. Kinzly introduced the user kit at the 11th International Conference on Drug Policy Reform of the Drug Policy Foundation in October. The 200 kits he brought were snatched up like hotcakes, says an eyewitness.

The user kit includes two condoms, antiseptic towelettes, triple antibiotic ointment, two alcohol swabs, five vitamin C tablets, copper wool, a few rubber bands, a rubber mouthpiece and a pamphlet with the following instructions: "Avoid cut lips, have safer sex, be careful with your stem or pipe." Following are instructions for "Safer Using" and "Things Not To Do." A person who had never used crack before would find the instructions quite helpful: "Use a glass or metal stem with mouthpiece. Don't get cut lips. Let pipe or stem cool down before taking

next hit to prevent burning or cutting lips."

According to Cathy Rigby, the program coordinator in Philadelphia, 200 user kits are supplied each week — at least 20,800 kits in the last two years. Kinzly says that some 2,300 user-kits were handed out in Bridgeport.

The "Shoot Smart, Shoot Safe," pamphlet, with "tips for safer crack injection" brochure, seems to mark a new development in the campaign to legalize, or "med-

icalize" illegal drugs. In addition to how-to instructions, the brochure contains pictures demonstrating proper injection. The instructions begin with "Get your stuff ready" and follows with a detailed recipe: "1) Have a cooker, water, syringe, citric or ascorbic acid (avoid vinegar or lemon juice, which can lead to serious infections), cotton and alcohol wipes ready; 2) Put crack and citric or ascorbic acid (about a pinch to a slab) in cooker. Add plenty of water; smash and mix well; 3) Add cotton and draw up into syringe."

It goes on to instruct: "Get a vein ready: 1) Tie off, find a good vein and clean with alcohol wipe; 2) Inject. Make sure you are in the vein, register, look for blood back flow in syringe; 3) Slowly push plunger in for injection. This helps to prevent vein trauma and collapse; 4) Withdraw needle. Apply pressure for about a minute. Use clean gauze, tissue, cloth or whatever you have handy." The pamphlet also recommends to rotate injection sites, use antibiotic ointment and drink plenty of fluids.

Kinzly explains that since there is an emerging trend of injecting crack among users, citric and ascorbic acid are handed out with brochures for "safe injecting tips." Bridgeport's main goal, he says, is to eliminate or decrease the risky behavior associated with smoking and injecting dangerous drugs and thus to reduce HIV and AIDS infections.

The benefits of so-called harm-reduction programs have yet to be proved. However, if the recent results of an epidemiological study in Vancouver, British Columbia are any indication, we can expect that the expansion of needle-exchange projects will cause rapid growth of HIV and AIDS cases. Martin Schechter of the University of British Columbia found that Vancouver has one of the highest rates of HIV infection — nearly 20 percent annually — and among the worst AIDS epidemics in North America. This situation exists despite Vancouver's ambitious needle-exchange program, which started in 1988 and is the largest in North America. More than 2.5 million needles are distributed annually and many addicts, says Schechter, changed habits — instead of two or three heroin injections a day they switched to a dozen or more cocaine injections. "The number of injections per day goes up [while] the ability to take precautions goes way down," he said. "That's how you get this explosion." Quipped Robert DuPont, a former director of the National Institute on Drug Abuse, "the people who distribute these [kits] are not harm reductionists but harm productionists."

These things are done with the claim that this will reduce AIDS and HIV infections. "But the fact is that sexual promiscuity associated with crack is the lead[ing] cause for new cases of HIV and AIDS," says James Curtis, director of (continued on page 27)

s y m p o s i u m

treatment now and before we came along, they didn't even know it was available."

Rich, a Bridgeport addict, loathes his desperate condition and wants desperately to kick his addiction. He came to the van for needles, advice and some comfort. Several months

ago he said, "If I can ever beat this I don't want to beat it and then have AIDS." That is consistent with what a Liverpool drug worker told me many years ago over a bowl of soup at my dining-room table: "It is very hard to rehabilitate a dead addict."

EHRENFELD: continued from page 25

psychiatry and substance-abuse services at Harlem Hospital Center and a professor of psychiatry at Columbia University College of Physicians and Surgeons. "And giving two condoms to crack users is a cynical gesture," he adds. Curtis says, "Crack is the most addictive of all drugs and it has the most devastating effect of all illegal drugs. We have at least 15 cases each day where crack caused people to behave violently so that they are brought to the psychiatric emergency room," he said.

"We read a great deal [arguing] that crack use is on the decline, but at Harlem Hospital psychiatric emergency room the drop is not noticeable as advertised. It is particularly distressing," says Curtis, "that at a time when crack use is apparently dropping, these people are promoting crack use. It seems that they are giving a jump start to a new epidemic. This is genocidal in effect, if not by intent, towards the black community. We can expect that this propaganda will have devastating effects on minority groups, will increase crime rates, prostitution, wreck family life and increase the number of neglected and abused children that require foster care. All would be the immediate consequences one can expect with such propaganda."

As for needle-exchange programs in general, Curtis' view is that these are "transparent attempts to legalize drugs," especially since those who participate in harm-reduction needle-exchange programs are exempt from arrest.

According to Kinzly, their project is widely supported by local public officials, leaders, politicians, well-known crack users and police officers. "Instead of arresting these guys, [the police] are bringing them to our van," said Kinzly. (The van is a converted bookmobile that can service about 20 addicts at one time.) He explains that the van is a "safe place, nonjudgmental and it belongs to the community it's serving." That community involvement had been the reason for their success, he adds proudly.

The nature of that success eludes those who have to deal with the drug epidemic. New York City Police Commissioner Howard Safir didn't mince words denouncing this activity: "Any governmental agency giving instructions how to utilize illegal substances, even with the best intentions, does a dangerous disservice to the public. Public agencies should encourage abstinence and treatment. This is a dangerous precedent."

Rep. Bob Barr, a Georgia Republican, reacting to news of distribution of the safe-use kits, says: "Everyone has seen that crack destroys lives, communities and neighborhoods. This

mind-destroying drug has cost America a generation, particularly in our inner cities. I can't think of anything more shortsighted, more ironically tragic, than assisting crack users with these death kits. America will pay a very dear price if we don't reverse this dangerous trend." "The irony of the pamphlet is sickening," agrees Rep. Mark Souder, an Indiana Republican. "It claims to tell a drug user how to smoke crack safely, but every single pointer highlights in glaring detail that there is no safety in drug use."

Former drug czar William Bennett says, "Distributing a 'safe crack-use kit' is a terrible, preposterous idea. These guys have gone off the deep end. There is no such thing as 'safe crack use.' What we're talking about is not rocket science. We know what crack cocaine does to people, medically, physically, spiritually. It devastates lives, and it triggers violence."

Psychiatrist Mark Gold, a professor at the University of Florida Brain Institute at Gainesville and one of the first to report on the crack-smoking phenomenon, warns: "Cocaine injection and crack smoking are the most devastating and dangerous among all other illegal drugs because their use is not associated with society. Use occurs in escalating hinges until the supply is exhausted or the user has a stroke, seizure or heart attack or some other major psychiatric disturbance. Based on scientific studies in humans, cocaine (and crack) use are impossible to control. Suggesting that crack can be used safely is misguided, naïve and dangerous."

With the advantage of Soros' checkbook advocacy and advanced marketing techniques, which lean heavily on emotional arguments for compassion, prolegalization initiatives to "medicalize" or decriminalize drugs in the United States by the end of 1998 are in full gear. (Although drug czar Barry McCaffrey has opposed using federal funds for needle exchanges, our repeated requests for McCaffrey to condemn distributions of the kits were ignored.)

As for the direction these "safe crack-use" kits are leading, perhaps Bennett said it best when he recently wrote: "We ought to take this as a warning about where many of the drug legalizers ultimately want to go. The brave new world of drug legalization would leave us with a society filled with far more drug addiction, more violence and more wasted and lost lives. That's precisely why we have to fight to see to it that their ideas don't prevail."

This mind-destroying drug has cost America a generation. I can't think of anything more shortsighted than assisting crack users with these death kits.

Mr. MICA. Another unanimous consent request to insert "Crack Smokers Directions," here from the Drug Treatment Services of the Bridgeport Connecticut Health Department.
[The information referred to follows:]



Other Suggestions:

- If your pipe or stem is unsafe (broken mouth piece or hardened choy) wrap a matchbook cover or rubber band to secure it. You can also make a pipe from a plastic bottle or a can using cigarette ashes as a filter. Beware, cans and tin foil can get very hot!
- If it tastes wrong, don't smoke it! Everything that looks like crack, isn't!
- If you smoke indoors, make sure it is ventilated. Poorly aired rooms can be risky for tuberculosis (TB). Cover your mouth when coughing.
- If you have problems breathing or are coughing up dark stuff, slow down or stop smoking for a while! See a doctor is it continues!
- If you think that you have a sexually transmitted disease, come to the free clinic, get tested.
- Come to any of our sites for more information. If you are looking for detox or rehab, we can connect you with our drug treatment advocate.

Needle Exchange Program Programa de Intercambio de Agujas

Monday-Tues

10:15 - 11:45 PT Barnum Apts. (Taylor Dr.)
12:00 - 1:15 Downtown - Middle Street
1:30 - 2:00 Beardsley Terrace
2:15 - 2:45 East Main Street & Arctic St.
3:30 - 4:30 Marina Village
5:00 - 6:15 PT Barnum Apts.
6:30 - 7:15 Fairfield Ave.
7:30 - 8:30 Green Apts.
9:00 - 9:30 James St. & Haral Ave.

Tuesday - Martes

10:30 - 12:00 PT Barnum Apts.
12:15 - 1:30 Downtown - Middle Street
1:30 - 2:30 Marina Village
3:30 - 4:30 PT Barnum Apts.
5:00 - 6:30 Stratford Ave.
6:45 - 7:30 East Main Street
7:45 - 8:30 Marina Village
8:45 - 9:30 Ionian Ave & Fairfield Ave.

Wednesday - Miércoles

10:30 - 12:00 PT Barnum (Taylor Drive)
12:30 - 2:45 Downtown - Middle St. (Women's Crip)
3:15 - 3:45 Evergreen Street
4:00 - 5:15 PT Barnum
5:30 - 6:30 Marina Village
6:45 - 7:30 East Main Street
7:45 - 8:30 Catherine Street
8:45 - 9:30 James St. & Haral Ave.

Thursday - Jueves

10:30 - 12:00 PT Barnum
12:00 - 1:15 Downtown - Middle Street
1:30 - 2:00 Marina Village
2:15 - 2:45 East Main Street

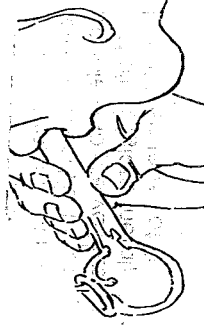
Friday - Viernes

10:30 - 12:00 PT Barnum Apts

Drug Treatment Services
576-7238

funding provided by Ford Policy Foundation

Pipers (Crack) Smokers:



**AVOID CUT LIPS
HAVE SAFER SEX
BE CAREFUL WITH
YOUR STEM OR PIPE**

**BRIDGEPORT HEALTH
DEPARTMENT
576-7679**

**TAKE CARE!
DON'T SHARE!**

“Crack” or “Rock”

cocaine may lead to sexually transmitted diseases (STDs) such as HIV/AIDS, syphilis, or gonorrhea as well as other diseases like tuberculosis (TB).

By engaging in unsafe practices and/or unsafe sex, people who use various types of pipes (glass, metal) can put themselves at risk for these diseases.

Don't get cut lips!

Cuts caused by sharp or hot pipes can expose “pipers” and others to infectious diseases, especially when you have oral sex without a condom, dental dam or a latex barrier. If there is blood or saliva on your pipe or stem, thoroughly wipe it off immediately! Use a pipe or stem with a taped or rubber covered mouthpiece.

SAFER USING

1. Use a glass or metal stem with mouthpiece. DON'T get cut lips.
2. Don't share your stem or pipe. If you do, wipe the mouthpiece before using.
3. Use a clean choy or copper wire. Pipe screens are best.
4. If using a plastic bottle for a pipe, remember to change the foil. Keep clean ashes. Wipe mouth holes before using.
5. Try not to binge! Take time between hits.
6. Drink water as often as possible. Try to eat something.
7. Get rest.
8. Let pipe or stem cool down before taking next hit to prevent burning or cutting lips.
9. Have safer sex! Always use latex

UNSAFE USING

“THINGS NOT TO DO!”

1. Smoking from a pipe or stem that doesn't have a rubber covered mouth piece.
2. Smoking from a hot pipe.
3. Smoking from a cracked pipe.
4. Not wiping the stem pipe when you share.
5. Giving or receiving “shotguns.”
6. Using plastic bottles as pipe without changing tin foil or keeping fresh ashes.
7. Smoking with cracked lips
8. Having sex without latex condoms or dental dams, especially when on a binge.



004-009-008-1

23970h

Mr. MICA. Additional unanimous consent request to submit an article entitled, "High on a Lie," by Daniel Levine.
[The information referred to follows:]

Funded by billionaires, the "medical marijuana" movement is blowing smoke in our eyes

High on a Lie

BY DANIEL LEVINE

ON SATURDAY last September, 25,000 people, most of them teenagers, crowded into the Boston Common for the annual Freedom Rally. Its organizers billed it as the largest marijuana-legalization event on the East Coast. Strolling through the crowd, holding a joint, was a 17-year-old high school senior who said his name was Bill. "If they allow sick people to use it," he said, "it can't be that damaging."

Sharing a marijuana pipe with two friends, 15-year-old named Nicole agreed, "It's harmless," she said. "It would be legal and it would be good for you with a lot of things. It's the best."

An increasing number of young Americans agree. They have gotten this idea from a well-funded movement to legalize the "compassionate" use of marijuana. While every legitimate drug requires rigorous

testing by the FDA before being approved, marijuana advocates are opening for medicine by popular vote. The year signatures are being gathered for medical-marijuana initiatives in a half-dozen states and the District of Columbia.

Marijuana's main active ingredient, THC, is effective in relieving nausea and inducing weight gain in cancer and AIDS patients. That is why the FDA has approved Marinol, a synthetic pill form of THC. But marijuana in its smokable form has never been shown in controlled scientific studies to be as effective. In 2000, the National Cancer Institute reported that many of which produce psychoactive reactions, cause lung damage and—in cancer and AIDS patients—increase the risk of pneumonia and weaken the immune system. Inhaling the smoke also disrupts short-term memory and leads to changes in the brain similar

to those caused by heroin, cocaine and other highly addictive drugs. "There is no conclusive scientific evidence that marijuana is superior to currently available medicines," says Dr. Eric Voth, chairman of the International Drug Strategy Institute in Omaha. "Medical marijuana is a scam that takes advantage of sick and dying patients."

Says Gen. Barry R. McCaffrey (R-Cal.), director of the Office of National Drug Control Policy, "Medical marijuana is a stalking-horse for legalization. This is not about compassion. This is about legalizing dangerous drugs."

"Daddy Warbucks" of Drugs. The legalization of marijuana and other drugs has been debated for more than 30 years, with a vast majority of Americans standing in opposition. Legalization supporters have used the argument that drugs are necessary for medical reasons. But now, for the first time, they have significant financial backing.

In the last six years a handful of America's wealthiest people have contributed \$20 million to groups that promote medical marijuana. Efforts include drug-policy reform. Efforts include drug-policy reform. Efforts include drug-policy reform.

On the other hand, the biggest financial force behind the movement is George Soros, the hedge-fund manager, philanthropist, and CEO of Clatskanie, Ore. Soros, CEO of Clatskanie, Ore. Soros, CEO of Clatskanie, Ore.

In an interview with Reader's Digest, the 76-year-old Soros said he believes doctors should be allowed to pre-

READER'S DIGEST

scribe all drugs, including heroin and LSD. Soros declined to be interviewed. A spokesman for Soros said he does not support drug legalization.

Nonetheless, Soros has donated millions since 1992 to groups led by people advocating it. Former Health, Education and Welfare Secretary Joseph A. Califano, Jr., calls him the "Daddy Warbucks of drug legalization."

Soros created a drug-policy institute called The Lindesmith Center and has funded it with \$1 million. Its director, Ethan Nadelmann, Soros's point man on drug policy, has said he wants to "legalize the personal possession of drugs by adult Americans."

Soros has also given \$6.1 million to the Drug Policy Foundation (DPF), a leading advocate for medical marijuana. Its stated mission is "publicizing alternative to current drug strategies." Its founder, attorney and lobbyist, says Arnold Tekach, calls himself a "free-market capitalist."

Can the repeal of current drug laws (Richard J. Dennis, a 49-year-old Chicago-area lawyer, is a DPF member of DPF's board of directors, which includes medical marijuana advocates.) "I'd like to see legislation for adults for all drugs, including heroin."

On DPF's advisory board is Harvard Medical School psychiatrist Lester Grinspoon, a leading advocate of medical marijuana for over 25 years. He compares marijuana's potential benefit to that of penicillin, predicting, "It will be the wonder drug of the

new millennium."

Soros, Lewis and Sperling gained their biggest victory in November 1996 when California voters passed Proposition 215, also known as the Compassionate Use Act. It allows pot to be grown and smoked for "any illness" and "can include headaches, chronic pain and arthritis. A doctor's oral recommendation is all that is required."

The principal author of the California initiative was 52-year-old Dennis Peron, a San Francisco medical pot club owner who's been arrested 15 times on marijuana charges. Peron says he wanted the initiative vaguely because he believes "all marijuana use is medical."

Peron's Cannabis Cultivators' Club is the state's largest pot club, taking in \$250,000 a day. One day last fall Peron's club got a letter from the federal government demanding a quarter-pound bag of marijuana. Peron refused to give it up. He said he was a 39-year-old named Anthony. Under California's law, Anthony is

considered a "seriously ill patient" who can purchase and smoke pot. He takes up four or five times a day. When asked about his ailment, Anthony answered: "Officially, heroin discomfort from overstimulation. Actually, I can't feel it."

He said the club admitted him without any medical referral. A self-described "potaholic," Anthony has smoked dope since he was 16. "My problems," he conceded, "are related to a general life-style kind of thing."

Peron's club had operated for years, despite the fact that state and federal agencies raided it, seizing 86 pounds of pot and \$62,000. "The club was running a sophisticated illegal drug distribution network," said a spokesman for California Attorney General

HIGH ON A LIE

Behind the Pot Vote

George Soros

\$550,000

Peter Lewis

\$500,000

John Sperling

\$200,000

Californians for Medical Rights

Campaign for the "Compassionate Use Act" to legalize medical marijuana

FOR MORE INFORMATION, VISIT US AT WWW.CMRA.ORG

PHOTOS: JOURNAL OF CALIFORNIA INVESTIGATION; LEVINE: JAMES FAY/ANSA

One of the numerous medical-marijuana clubs that opened as a result of Peron's measure was the Dharma Producers Group in San Francisco, which bragged that it offered "medical marijuana with a Tibetan touch." The club's "medical director," a ponytailed 52-year-old named Lorenzo Pace,

The measure passed, but a post-election survey revealed that Arizona voters had been badly misled. Seventy-

HIGH ON A LIE

Despite being outstep more than 100 years to one, opponents of the Washington Initiative are not about to be caught unprepared. They took every opportunity to stress that the measure was not about compassion, but about legalizing dangerous drugs. Last November, they were asked to provide a

Let us know what you think about this topic at www.readersdigest.com.

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Mr. MICA. And any other materials submitted without objection will be made a part of the record.

[NOTE.—Substantial additional information referred to may be found in subcommittee files.]

[The information referred to follows:]

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PAOLI, PA 19301
(610) 640-9064

MIGRATORY BIRD
CONSERVATION COMMISSION
REPUBLICAN POLICY COMMITTEE
E-mail: cunpa7@hr.house.gov



APR 17 1997

Congress of the United States
House of Representatives
Washington, DC 20515-3807

April 15, 1997

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THIS IS YOUR BRAIN ON DRUGS

Dear Colleague:

Like many of you, my office constituent E-mail system has been filled with correspondence from people all over the United States arguing the case for the legalization of Marijuana. Their arguments, while disjointed and difficult to follow, present an excellent case for the continued restrictions on Marijuana. For your amusement and interest, please find below a small sample of reasons why drugs continue to hurt our youth.

"The people who use Marijuana are only hurting themselves."

-Nick

"I FEEL THE MARY JANE SHOULD BE LEGALIZED. SHE MEANS NO HARM TO THOSE WHO DO NOT BELIEVE THAT SHE IS A BRINGER OF PEACE. MANY PEOPLE HAVE THIS BLINDED POINT OF VIEW ABOUT MY BABY, BUT THAT IS PREJUDGING THE POWER OF THE PLANT."

-Anonymous

"I know what your [sic] thinking, right some kid who listens to heavy metal until his brains come out his head, and tells his mom to f**k off!!

-Nicholas

"I am a victim of the so-called "drug wars." In Oct 1994, I lost my privilege to drive an automobile for 6 months just for the simple reason of being in the possession 2 small "roaches."

-Christopher

"AND I QUOTE "ALL MEN ARE CREATED WQUAL""

-Scott

"Legalize it now f**kers"

-Adam

"it would stop the drug war and make a lot of people happy if you made the d*mn sh*t LEGAL, LEGAL D*MN IT, YOU HEAR ME, I KNOW THAT YOUR READING THIS LETTER, AND well thats it!!!!"




-Nicholas

I hope you find their arguments as convincing as I do.

Sincerely,

CURT WELDON
Member of Congress

Behind the Pot Vote

		
George Soros \$550,000	Peter Lewis \$500,000	John Sperling \$200,000

↓ ↓ ↓

Californians for Medical Rights
Campaign for the "Compassionate Use Act"
to legalize medical marijuana

SOURCE: CALIFORNIA SECRETARY OF STATE'S OFFICE

Mr. MICA. As I said, we will leave the record open for at least 2 weeks if additional documentation and information is wished to be submitted either by the public or other groups.

There being no further business to come before the subcommittee, I would first like to thank each of the panelists for their patience and participation and for their contribution today.

It is a difficult subject, and there is a lot of controversy surrounding it and difference of opinion. But we hope to continue this discussion and again hear these topics fairly and openly in future panels. Thank you.

This meeting of the subcommittee is adjourned.

[Whereupon, at 3:30 p.m., the subcommittee was adjourned.]

